Missouri State Board of Nursing Newsletter

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Message from the President

What Does My Renewal Fee Pay For?

Roxanne McDaniel, PhD, RN

With the RN renewal period upon us, some of you may be wondering what your renewal fee pays for. As a licensee who pays fees, you have the right to know how the funds you pay are expended. Nursing regulation is the governmental oversight provided for nursing practice in each state. Nursing is regulated because it is one of the health professions that pose risk of harm to the public if practiced by someone who is unprepared or incompetent. The public may not have sufficient information and experience to identify an unqualified health care provider and is vulnerable to unsafe and incompetent practitioners. Through regulatory processes, the government permits only individuals who meet predetermined qualifications to practice nursing. The Board of Nursing is the authorized state entity with the legal authority to regulate nursing.

The Missouri State Board of Nursing approves individuals for licensure, approves educational programs for nurses, investigates complaints concerning licensees' compliance with the law, and determines and administers disciplinary actions in the event of proven violations of the Nurse Practice Act.

Effective January, 2013, the renewal fee is $60 for Registered Nurses and $52 for Licensed Practical Nurses. $10 of the RN and $2 of the LPN fee is deposited in a fund with the Department of Health in order to administer the nursing student loan program. You can access more information about the nursing student loan program at http://health.mo.gov//living/families/primarycare/healthprofloans/index.php

The top three budget items for our office are professional services to investigate complaints, supplies and salaries. Supplies include postage. This year, we will mail approximately 97,000 renewal notices for a total postage bill of approximately $31,000. One of the ways costs can be decreased is to keep your address current with our office and renew online EARLY.

The Board of Nursing's fund is also assessed costs from the Division of Professional Registration, Department of Insurance, Financial Institutions and Professional Registration and Office of Administration. These costs include services such as computers, information technology support, purchasing staff, accounting staff, web site maintenance, and licensing renewal processing staff. In addition, our office utilizes the Office of the Attorney General for some of our legal counsel work. Transfers total approximately 33% of our annual budget, while direct costs spent by our Board account for approximately 67% of our annual budget.

RNs renew every two years in odd-numbered years and LPNs renew every two years in even-numbered years. Since there are more RNs than LPNs, the Board receives more revenue in odd-numbered years than in even-numbered years. The RN renewal cycle is February to April. The LPN renewal cycle is March to May. When determining revenue and expenses, the Board has to plan to have enough reserve in the fund to pay expenses until the revenue from renewal fees is received. State statute 335.036.4, RSMo, indicates that the Board of Nursing funds "shall not be transferred and placed to the credit of general revenue" unless the amount in the fund at the end of the year exceeds two times our appropriation. This prevents the Board from charging excessive fees and also explains why renewal fees may fluctuate from year to year.

During the Board's quarterly face-to-face meetings, the Board diligently reviews financial statements. We are very cognizant of the fact that nurses pay for the operation of the Board and continually look for ways to cut costs.

Most of the State budget cuts are to state agencies that operate from tax dollars, commonly referred to as general revenue. The Missouri State Board of Nursing operates on fees collected from licensees. This does not mean that we are not affected by budget cuts. Since we are assessed fees through cost allocation plans, as other agencies suffer budget cuts, our cost allocation may increase. We review changes to projections and cost allocation plans at our quarterly Board meetings and make necessary adjustments.

As Board members, we are responsible for ensuring that monies are managed in a legal manner that is consistent with the mission of the Board. Additionally, the Board ensures the financial stability of the organization by making sure we have sufficient funds to carry out the activities required of the mission. These fiscal responsibilities are carried out in accordance with state and federal laws.

Executive Director's Report

Authored by Lori Scheidt, Executive Director

National Council of State Boards of Nursing Announces E-Notify: The Future of Licensure and Discipline Notification for Employers

Every year, boards of nursing (BONs) across the U.S. contact thousands of their nurses to remind them to renew their nursing licenses. Some BONs send emails; others send postcards and letters. It is then the responsibility of the nurse to renew their license. Left out of this equation, however, are the employers who rely on nurses to have current licenses to practice. Previously, the only way for employers to know if a nurse's license was about to expire was to look it up, one nurse at a time. And when it came to learning about discipline status, employers were left out of the loop again, having to seek this information on their own. Not anymore.

Institutions that employ nurses have the ability to receive automatic licensure and discipline notifications about their nurses quickly, easily and securely with NCSBN's new Nursys® e-Notify system. Launched December 3, 2012, e-Notify is an innovative nurse licensure notification system that automatically provides employers licensure and publicly-available discipline data as it is entered into Nursys by BONs. Employers will no

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current resident or

Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)	573-636-5659
Missouri Nurses Association (*MONA*)	573-636-4623
Missouri League for Nursing (*MLN*)	573-635-5355
Missouri Hospital Association (*MHA*)	573-893-3700

NLCA Announces Election Results

On Oct. 1, 2012, the Nurse Licensure Compact Administrators (NLCA) announced the annual elections results for its Executive Committee:

Lori Scheidt, MBA-HCM, executive officer, Missouri Board of Nursing, was elected vice-chair.

Kennetha Julien, JD, executive officer, Colorado Board of Nursing, was elected treasurer.

Lorinda Inman, MSN, RN, executive officer, Iowa Board of Nursing, was elected member-at-large.

Each term began Oct. 1, 2012, and ends Sept. 30, 2014. Positions on the six member committee are for two-year terms and are staggered so that three positions expire each year. A member may be re-elected to the same position for one additional term.

In addition to the newly elected NLCA Committee members, the committee is comprised of Joey Ridenour RN MN FAAN, chair (executive officer, Arizona Board of Nursing), Connie Kalanek, PhD, RN, FRE, member-at-large (executive officer, North Dakota Board of Nursing), and Sandy Evans, MAEd, RN, APRN, member-at-large (executive officer, Idaho Board of Nursing).

We need your input! Help Us Plan for the Future!

Authored by Mary C. Becker
Senior Vice-President of Strategic Initiatives and Communications Missouri Hospital Association

WE NEED YOUR HELP! Make your mark and help Missouri nurses plan the future of nursing.

We know that 80 percent of Missouri is designated as a health professional shortage area. We also know that 14 percent of Missourians are 65 and older. Those two facts would indicate that Missouri will need more nurses in the future. But, we don't know how many actually work in the state!

Tell us more about your nursing background by visiting the Missouri Health Professionals Registry website at www.missourihealthprofessionalsregistry.org. It takes less than five minutes to complete. You'll answer simple questions like the languages you speak, where you went to school and what you are doing now.

The data you provide is important and here's why.

- Missouri needs to plan to care for an aging population and we already have a shortage of health professionals.
- We don't know much about our nursing workforce, and that makes it difficult to plan the future of nursing. Where do Missouri's nurses work? What setting do you work in? What are your specialties and educational background?
- Knowing this basic information about the nursing workforce will help nursing advocates plan. It will help allocate future resources including scholarships, educational facilities and faculty.

Missouri's nursing workforce needs to be understood and YOU are part of this story!

The Missouri Health Professionals Registry was created by the Missouri Department of Health and Senior Services with help from the Missouri State Board of Nursing. Your information is private. The data you enter will only be used to help us direct resources and understand the nursing workforce in Missouri.

This important initiative is endorsed by the Missouri State Board of Nursing, Missouri Nurses Association, Missouri Department of Health a and Senior Services, Health Care Foundation of Greater Kansas City, LeadingAge Missouri, Missouri Action Coalition, Missouri Alliance for Home Care, Missouri Foundation for Health, Missouri Health Care Association, Missouri Hospital Association, Missouri League for Nursing, Missouri State Association of Licensed Practical Nurses and Missouri Organization of Nurse Leaders.

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Number of Nurses Currently Licensed in the State of Missouri

As of December 31, 2012

Profession	Number
Licensed Practical Nurse	23,647
Registered Professional Nurse	97,548
Total	**121,195**

http://pr.mo.gov

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longer have to proactively seek licensure or discipline information of nurses in their employ; that information will automatically be sent to them.

The e-Notify system alerts subscribers when changes are made to a nurse's record, including changes to license status, license expirations, license renewal, and public disciplinary action/resolutions and alerts. This means that if a nurse's license is about to expire, the system will send a notification to the employer about the expiration date. Employers can also immediately learn about new disciplinary actions issued by a BON for their employed nurse, including receiving access to available public discipline documents.

Benefits

The information in e-Notify is pulled directly from Nursys, the only national database for licensure verification, discipline and practice privileges for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs). Nursys data is compiled from information directly inputted from BONs (in participating jurisdictions; visit nursys.com for current participation list). The system provides real-time automatic notification of status and discipline changes delivered directly to institutions.

Cost

All institutions are given 100 credits free of charge. This means that the first 100 nurses enrolled into the system are free. After that, the cost is $1 per nurse, per year. A facility that employs 25 nurses would pay nothing to utilize e-Notify; a facility with 150 nurses would only pay $50 per year.

A unique feature of e-Notify is the ability for institutions to turn a nurse's notification setting on or off, choosing whether or not to receive notifications about a specific nurse's licensure or discipline status. Only nurses who have their notifications turned on are charged against one of the employer's 100 free credits.

Customizable Features

It's entirely up to the institution to determine how often they want to receive notifications about their nurses. They have the option of receiving email notifications daily, weekly or monthly. For licensure renewal notifications, institutions can choose to receive alerts 30, 60 or 90 days prior to a nurse's license expiring.

Ease of Use

Institutions can enroll nurses into e-Notify easily either as an individual or through bulk upload; all that is needed is the nurse's license number, license type and the state that issued their license. This information is used to locate the nurse directly from the Nursys database. Once nurses are enrolled, institutions can access their nurse list and download the data at anytime.

Another unique feature of e-Notify is its search functionality. Rather than searching for a nurse by his or her name, e-Notify only allows institutions to search by licensure number. This way, if a nurse changes their name with the BON, that information will automatically be updated in e-Notify, decreasing the likelihood of multiple entries being entered into the system for the same person.

When enrolling a nurse in e-Notify, institutions also have the option of including the nurse's email address and/or cell phone number. Institutions can send automatic email reminders, as well as text messages, to nurses securely.

With e-Notify, any institution that employs a nurse can utilize this system to track licensure and discipline information for little or no charge. e-Notify is an innovative tool that provides vital information to employers, saving them money and staff time.

The Difference Between Boards & Associations

The Missouri State Board of Nursing (Board) is aware that there can be confusion regarding the difference between the Board and nursing organizations or associations. The article provides a brief summary of the role of the Board and the role of associations; how they differ and what they have in common.

- The Missouri State Board of Nursing is a regulatory board. It is an agency of state government that was established through enactment by the Missouri General Assembly (the state legislature) of a law that mandates both the structure of the Board and the Board's functions. The Board consists of 9 individuals, 5 of whom must be RNs, 2 whom must be LPNs and one public member appointed by the governor. Board members are public officials and their meetings are open to the public, as are many of their records. The regulatory body is a governmental body to which individual health care practitioners **must** pay fees (called licensure fees) in order to practice legally in the state of Missouri.
- Associations and organizations include the Missouri League for Nursing, Missouri Nurses Association, the Missouri Association of Licensed Practical Nurses, the Missouri Association of Nurse Anesthetists, and state chapters of other specialty organizations such as operating room nurses, critical care nurses, occupational nurses, school nurses and other nursing specialty groups. A board of trustees elected by association members typically runs associations. Association meetings can be closed to the general public. The association is a nongovernmental body whose members pay voluntary membership dues.

Associations and the Board of Nursing share the goal of providing safe care to the citizens of Missouri; however, their ways of accomplishing this goal are significantly different.

- The Board exists solely to enforce the law and rules regulating practice. The Board has authority to establish requirements individuals must meet to obtain a license to practice nursing. The Board approves pre-licensure nursing education programs, oversees the licensure examination of nurses, and takes disciplinary action when a licensee violates the law. These activities help to assure that only qualified individuals provide care to the public.
- Associations bring practitioners together to develop professional standards and practices, codes of ethics, and to promote and protect the economic and general welfare of nurses These activities also enhance patient safety by helping to improve the quality of the nursing care provided. Associations provide service to their members and represent the individuals who are part of that profession.

Enforcing the law

- When regulatory boards enforce the law, they impose penalties on individual licensees for failure to practice in accordance with that law. Those penalties may include a censure (reprimand), a practice restriction (probation), a suspension from practice, or a permanent revocation of the privilege to practice. The severity of the action taken depends upon the violation as well as aggravating and mitigating circumstances. It is important to note that the Board of Nursing enforces the law and rules regulating the practice of nursing as the law currently is stated, not how individuals may wish the law to be. The Board only has the authority to take disciplinary action against those who are regulated by the Board. Those who are regulated by the Board are RNs, LPNs and APRNs. The Board may investigate situations that involve the activities of those who are not RNs, LPNs or APRNs. However, the Board cannot take action in cases involving non-licensees without the assistance of county prosecutors willing to prosecute the unauthorized practice of nursing. The Board can gather all the evidence proving unauthorized practice but must depend upon the county prosecutor to actually bring charges against the individual.
- The Board does not have authority over the employers of nurses. Mandatory overtime, double shifts and other similar employment issues are outside of the Board's authority. But if an employer is directing nurses to act in ways that are not consistent with standards of safe care, as those are set forth in the law, the Board may be notified and a complaint may be filed so an investigation can proceed.

Licensure Information

Authored by Angie Morice
Licensing Administrator

Registered Nurse licenses expire April 30, 2013

Registered Nurse licenses will expire on April 30, 2013. The fee to renew your RN license is $60.00. Nurses frequently call the office to inquire about license renewal procedures. Some of the calls occur because renewal notices are not received. Renewal notices are mailed three months prior to the expiration date to the address we have on file.

Please notify the Board of Nursing office in writing of all address changes. You must either renew online or with a paper renewal. You cannot renew by sending only a fee. If you need a paper renewal, you may either detach the request from the renewal notification and mail or fax the request to our office or fax a written request with your name, license number, address and your signature. A paper renewal will then be printed and mailed to you. **You can request a duplicate renewal form by visiting our website at www.pr.mo.gov/nursing and clicking on the link under RNs Now Renewing!**

Approximately 97,000 renewal notifications were sent to RN's in early February. Unfortunately not all are delivered. Many are returned undeliverable because the post office determined the licensee has moved.

The State Board of Nursing will no longer issue a paper verification to licensees who opt to come to the Board office to renew his/her license. **Renewals in person are NOT quicker.** If you have waited until the last minute to renew your license, you may come to the Board of Nursing office to renew your license. However, you will **NOT** receive your license or verification that day. We are not able to verify renewals mailed in late, at the last minute, or in person. It can take up to five business days to renew a license.

Please note: You will **not** be issued a new wallet-sized card with this renewal. On January 1, 2010, Missouri eliminated the issuance of license cards for regular license renewals. New licensees will be issued one initial licensure card which will contain the nurse's name, profession and license number. There will be no expiration date on these licensure cards. Go to www.nursys.com to verify multistate or single state license status, discipline and expiration date.

License Suspension Due to Tax Compliance Law 324.010, RSMo

Pursuant to 324.010, RSMo, all persons and business entities renewing a license with the Division of Professional Registration are required to have paid all state income taxes and also are required to have filed all necessary state income tax returns for the preceding three years. If you have failed to pay your taxes or have failed to file your tax returns, your license will be subject to immediate suspension within 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file. **The Board has no discretion in this matter.** The license is suspended by operation of law.

If your license is suspended because of non compliance of state income taxes, you must stop practicing as a nurse immediately and you can not return to nursing practice until your license is active again. If you have any questions, you may contact the Department of Revenue at 573-751-7200.

Name and address changes

Please notify our office immediately of any name and/or address changes in writing. The request must include your name, license number, your name and/or address change and your signature. An address/name change form can be found at http://pr.mo.gov, the form may be downloaded from our website and submitted. Methods of submitting name and/or address changes are as follows:

- By faxing your request to 573-751-6745 or 573-751-0075.
- By mailing your request to Missouri State Board of Nursing, PO Box 656, Jefferson City, Missouri 65102.

Changing your address with the post office will not ensure that important information such as renewals, newsletters, complaint information, etc. will be mailed to your new address. It is imperative that you complete the Name and Address Change form and submit it to the Missouri Nursing Board.

Contacting the Board

In order to assist you with any questions and save yourself and our office staff valuable time, please have the following available when contacting the Board:

- License number
- Pen and paper

Avoiding Unprofessional Behavior Allegations

by Angie Matthes, RN, MBA/MHA

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Have you ever been treated poorly or received poor customer service? What impression of the person or business did you have following the poor service you received? Do your patients have a positive or negative perception of the care they receive based on how you interact with them? The Board of Nursing has been receiving a growing number of public complaints about nurses who are perceived as unprofessional, rude, uncaring, condescending and impatient.

What do you consider rude and unprofessional behavior? We can all recognize these behaviors in someone else, but can we recognize this within our own behaviors? Have you ever heard or made comments like these? "That patient is such a pain." "That patient is crazy." "I am so sick of that patient calling me every 5 minutes." Consider how this would make you feel if this were said about you or someone you loved. While most of the time comments like these are said out of frustration and not meant for the patient to hear, you never know when they may be overheard. Nurses seem to be under more pressure today due to higher patient acuity, fewer staff and resources, and increased demands. In response to these stressors, nurses may react abruptly and convey a negative attitude without meaning to. However, patients and their loved ones rightfully expect to receive appropriate quality nursing care in a timely manner by caring and professional nurses. It is important to remember that it is how nurses present themselves to patients that can frame how patients view their entire healthcare encounter.

Consider the following scenarios:

Scenario # 1

Shortly after coming on duty, a patient lashes out at the nurse because he had not received his medication when he requested it. The nurse responded, "I just got here. We are short of staff and you are not our only patient." What kind of impression do you think this made on the patient? Did this demonstrate care and concern for his well being? What if instead, the nurse responded with, "I am sorry this occurred. Is the pain medication effective in relieving your pain or are you beginning to have pain before your next medication dose is allowed." Would you expect the patient receiving this response might feel the nurse showed empathy and a desire to help?

Scenario # 2

A confused patient is yelling at the nurse telling her to stop hurting her. The nurse responds, "Shut up. I am tired of listening to you whine all the time." A visitor overhears this interaction and reports that the nurse was disrespectful and abusive. Consider how you might feel if someone said this to your loved one. Do you think you would feel comfortable leaving your loved one with someone that demonstrated no concern?

Everyone wants to feel like they have been heard when they share concerns or needs. No matter how exceptional the nursing care is, a nurse that has been perceived as rude or uncaring may end up being the nurse that the patient or family remembers the most. Most nurses report that when they became a nurse they did so because they wanted to help people. In order to do this well, nurses have to consider how they react and respond in stressful situations. The time it takes to respond positively and professionally is much less than the time it will take to respond to complaints down the road.

There will always be a difficult day or a challenging situation, but it is worth the effort when a nurse remains professional and carries out his/her role to the best of his/her ability in the most caring and compassionate manner. Remember, when patients experience anxiety and fear, these feelings can often be displayed as frustration and anger. Nurses must recognize this and display compassion and understanding.

When all is said and done, patients and their loved ones will not likely remember every health care provider involved in their care, but they usually will remember their best and worst experiences. Only you can control with which group you will be placed. A simple please, thank you and sincere compassion will leave your patients with a positive experience and perception of their nursing care. Attitudes are contagious: let yours be positive!

Substance Abuse: Risks Factors and Protective Factors

Nancy Darbro, PhD, APRN, CNS, LPCC, LADAC, and Kate Driscoll Malliarakis, MSM, RN, CNP, MAC

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Addressing substance use disorders among nurses proactively and compassionately requires an understanding of the many risk factors that make nurses vulnerable. This article analyzes the specific risk factors that affect nurses, including nursing specialty, gender, and workplace, as well as the general risk factors for everyone. The article also discusses protective factors that help nurses avoid destructive substance abuse disorders and recover from them.

The prevalence of substance abuse and addiction among nurses and other health care professionals is no higher than the prevalence in the general population (Storr, Trinkoff, & Hughes, 2000). However, the prevalence of prescription drug misuse is 6.9% among nurses compared with 3.2% among white females (Substance Abuse and Mental Health Services Administration [SAMHSA], 1998). Nurses with substance abuse disorders not only provide patient care while impaired but also divert their patients' prescribed medications, risking patient harm. Despite this, the lack of identification and the underreporting of nurses and other health care professionals in the workplace remain an issue (Baldisseri, 2007).

Because nurses are the largest group of health care professionals, those who have abuse and addiction issues are more visible, more stigmatized, and more severely punished (Shaw, McGovern, Angres, & Rawal, 2004). To address substance use disorders among nurses proactively and compassionately, we need to consider the many risk factors that make them vulnerable.

The Effects of Specialty

The likelihood that nurses will use substances varies across specialties. The prevalence is higher among emergency department and psychiatric nurses (Anderson, 2004). Collins, Gollnisch, and Morsheimer (1999) also found higher rates of smoking in psychiatric nurses and significantly higher cocaine use in critical care nurses compared with other specialties. Oncology nurses and nurses listing their specialty as administration were more likely to consume five or more alcoholic drinks per occasion (Dunn, 2005).

Specialties least likely to report substance use were general pediatric, women's health, school, and occupational health nurses. The American Association of Nurse Anesthetists reported that the addiction rate among anesthesiologists and nurse anesthetists exceeds 15%. An anonymous survey of drug misuse among certified registered nurse anesthetists found that 10% reported misuse of controlled substances used in their practice (Bell, McDonough, Ellison, & Fitzhugh, 1999). Similar patterns have been found among physicians: Psychiatrists and emergency medicine physicians have higher rates (Hughes et al., 1999), suggesting common causes among health professionals with substance use issues.

The Effects of Gender

Because women make up 91.1% of registered nurses (United States Department of Labor, 2010), it is worth noting how addiction affects women. Women get sicker faster and have a more virulent course of addiction, perhaps because of their typically lower body weight and more intense reactions. Women tend to start substance abuse later in life and abuse fewer substances, yet they have more severe physical symptoms when they enter treatment (Goldberg, 1995; Mynatt, 1998).

Women tend to seek medical help for signs and symptoms associated with substance abuse, such as insomnia, nervousness, and depression, but the cause goes undetected by medical professionals because screening for substance abuse in primary care settings is uncommon. Women are more likely to associate the onset of substance abuse with a stressful life event or loss, and they have higher rates of comorbid psychiatric disorders, most commonly depression and anxiety (Blume, 1998; Goldberg, 1995). Typically, women enter treatment for substance abuse because of physical, mental health, or family problems; men tend to enter treatment because of a referral from an employer or the legal system (Blume, 1998). Men, who account for only about 9% of the nursing population, are overrepresented in the population of nurses in alternative programs and disciplinary cases (Dittman, 2008; National Council of State Boards of Nursing [NCSBN], 2009).

Other people, including family members, fail to recognize nurses with abuse issues as long as the nurses' behavior does not resemble the stereotype of an addict or alcoholic. Women with higher incomes or educations are even less likely to be identified and referred for treatment until they reach an advanced state of addiction (Blume, 1998).

Women who abuse drugs or alcohol experience a societal stigma for substance abuse as well as a moral stigma because women are held to a higher moral standard than men. For nurses, both men and women, the stigma of substance use is powerful, and addicted women and nurses remain hidden populations (Blume, 1998) and are less likely to receive treatment for substance abuse disorders than men (Greenfield et al., 2007).

General Risk Factors

The following general risk factors make people more susceptible to substance use disorders:

- *Psychiatric factors.* Depression, anxiety, low self-esteem, low tolerance for stress, learning disabilities, feelings of desperation, feelings of loss of control over one's life, feelings of resentment, and early victimization, particularly verbal, physical, and sexual abuse
- *Behavioral factors.* Use of other substances, aggressive childhood behavior, conduct disorder, antisocial personality disorder, avoidance of responsibilities, impulsivity and risk taking, alienation and rebelliousness, reckless behavior, school-based academic or behavioral problems, involvement with the criminal justice system, illegal behaviors, and poor interpersonal relationships
- *Social factors.* Early age (15 years or younger) at first use, alcohol-and drug-using peers, social or cultural norms condoning use, weak religious affiliation, expectations about the positive effects of drugs and alcohol, and access to and availability of drugs
- *Demographic factors.* Male gender, inner-city or rural residence with low socioeconomic status, and lack of employment opportunities
- *Family factors.* Alcohol and drug use by parents, siblings, or spouse; family dysfunction, such as inconsistent discipline and lack of positive family rituals and routines; poor parenting skills; and family trauma, such as death or divorce
- *Genetic factors.* Inherited predisposition to alcohol or drug dependence, deficits in neurotransmitters such as serotonin, and absence of aversive reactions, such as flushing or palpitations Studies estimate that genetic influences account for 40% to 60% of the risk for substance abuse (National Institute on Drug Abuse, 2007; Schuckit, 2009).

Workplace Risk Factors

The top four risk factors for nurses in the workplace are access, stress, lack of education, and attitude.

Access

The ready availability of drugs is an occupational hazard, especially when combined with a poorly managed administration of controlled substances in health care facilities (Trinkoff, Storr, and Wall, 1999). Sullivan, Bissell, and Leffler (1990) surveyed 300 nurses enrolled in treatment programs and learned that one sixth changed worksites (usually by internal hospital transfer) to have easier access to drugs in the workplace. On the other hand, Kenna and Wood (2004) found that reduced workplace access was related to a greater likelihood of using illicit substances among nursing students and that access is an important feature affecting substance use among health professionals.

The ongoing lack of institutional controls and oversight in the storing and distribution of narcotics facilitates diversion and its concealment. Loose prescribing practices for one's friends or family is another risk factor and reflects society's tolerance for taking drugs and expectation of receiving prescriptions from office visits. In one study, nurses did not seek appropriate medical care for self-diagnosed health problems; instead, they obtained prescriptions from physician friends without adequate workups (Solari-Twadell, 1988).

Stress

Nursing is a highly stressful occupation. In fact, nurses reported more on-the-job stress than any other group of health care professionals (Wolfgang, 1988). Long shifts, extra shifts, staffing shortages, and shift rotation contribute to increased stress. Trinkoff and Storr (1998) examined the relationship between work schedule characteristics and substance use and found that, in general, the more adverse the schedule characteristics, the greater the likelihood of substance abuse. The schedule characteristic most strongly associated with substance use was a combination of shift rotation and long shifts. Shift work and long work hours also lead to fatigue, sleep deprivation, circadian rhythm disruption, and other psychophysiological consequences (Geiger-Brown and Trinkoff, 2010). In a longitudinal study, adverse work schedules, including long work hours and limited time off to recover, were related to musculoskeletal injury, pain, and needlesticks (Trinkoff, Le, Geiger-Brown, Lipscomb, & Lang, 2006; Trinkoff, Le, Geiger-Brown, Lipscomb, 2007).

Self-medication for pain is always a concern among nurses. Bugle (1996) compared a group of nurses disciplined for substance abuse (n = 79) with a group of nurses not disciplined for substance use (n = 124). The findings: 40% of disciplined nurses used prescription drugs to control chronic pain compared with 20% of non disciplined nurses, and 42.5% of disciplined nurses used substances for emotional problems compared with 6.5% of non disciplined nurses.

Lack of Education

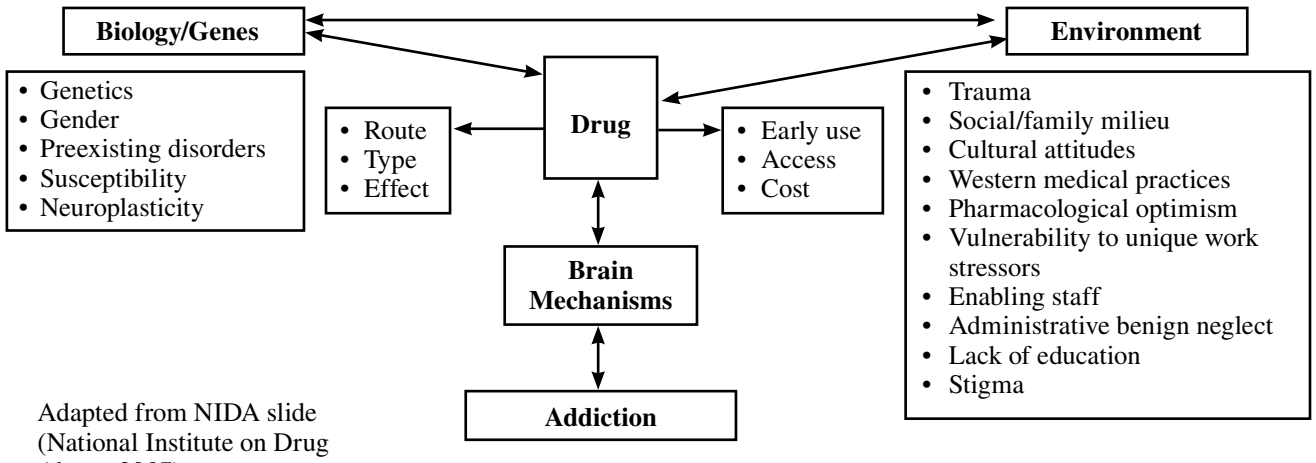
The lack of education on the addictive process and its signs and symptoms remains one of the more profound–and overlooked–risk factors for nurses. This lack of education contributes to the negative stereotypes of those with substance use disorders, especially nurses and physicians (Chappel, 1992; Grover & Floyd, 1998). Commonly, other health care professionals hold the most negative views of colleagues with substance use disorders (Howard & Chung, 2000a, 2000b).

Darbro (2005) interviewed many nurses who identified a lack of education and a culture of mistreatment in their workplace. Thus, as the adage goes, "Ignorance breeds

Figure 1

Risk Factors for Substance Use Disorders in Nurses

This figure is based on the classic epidemiologic triad–host (biology/genes), environment, and agent (drug)–and adapted to the specific risk factors for nurses.



Adapted from NIDA slide (National Institute on Drug Abuse, 2007)

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contempt," producing a work environment in which nurses with substance use disorders may take even greater pains to conceal their abuse, thereby increasing the risk of harm to all.

Attitude

Five attitudes can increase the odds of substance use problems in nurses (Clark & Farnsworth, 2006). First, nurses may see substance use as an acceptable means of coping with life's problems and a way of promoting enjoyment, comfort, and the ability to get along. Second, because of their training and daily observations, nurses may develop a faith in drugs as a means of promoting healing. This pharmacological optimism is a profound belief. The third attitude is a sense of entitlement that focuses on the nurse's need to continue working and rationalizations regarding drug use. The fourth attitude deals with the special status of health care providers as being invulnerable to the illnesses of their patients; health care providers see themselves as caregivers, not care receivers. Fifth, professional training involving powerful drugs leads to an acceptance of self-diagnosing and self-medicating for physical pain and stress.

Risk Factors in the Epidemiologic Triad

Figure 1 presents risk factors for substance abuse disorders based on the classic epidemiologic triad. Most risk factors in the figure are easily understood, but two may require explanation.

Western medical practices refers to Western medicine's reliance on pharmacotherapy as first-line treatment and the resulting expectation by patients that drugs will be prescribed as a quick fix for pain and other conditions.

Administrative benign neglect describes the common occurrence of health care administrators failing to recognize active substance use disorders and to intervene in a timely manner (Gossop et al., 2001). Because of this failure to act responsibly from the beginning, the disease may progress until the administration can no longer justify retaining the nurse. Thus, the only intervention is: "You're fired."

Protective Factors

Protective factors are much less studied in the literature, but they are critical for developing adequate prevention and support for nurses with substance use disorders and nurses who are at risk. Protective factors include beliefs in the values and norms of society, religious beliefs, and strong early attachment to a parent (Simoneau & Bergeron, 2000). Other protective factors include work satisfaction, workplace social support, and workplace constraints regarding use (Simoneau & Bergeron, 2000). Age can also be a protective factor because the highest risk of substance abuse is young adulthood and the prevalence of substance use declines with age (SAMHSA, 2008).

For those participating in a recovery monitoring program, the elements assessed to verify abstinence and recovery behaviors can also be considered protective factors. One physician healthmonitoring program postulated that the following factors were predictive of a successful recovery program (Talbot & Wilson, 2005, p. 1197):

- A high number of 12-step support group meetings attended each week
- High-quality, frequent contact with a 12-step sponsor
- Random, observed urine drug screens
- Close evaluation of emotional reactions to the hurdles of recovery, such as dealing with guilt, shame, anger, depression, and insomnia
- Immediate attention to other compulsive behaviors that emerge, such as gambling, food, sex, and work
- Consistent review and evaluation of treatment and medication status
- Assessment of family relationships and inclusion of family members
- Support and verification of medical and physical health status
- Regular questioning regarding and support of leisure or fun activities
- Intense scrutiny of compliance with all contract agreements
- Regular questioning regarding and support of regular exercise
- Regular questioning regarding workplace stressors and support
- Regular questioning of financial status and problems
- Regular questioning of need for additional training or education
- Questioning of participant's own evaluation of progress in recovery
- Identification of weak points in the participant's recovery or support through monitoring program

These factors have also been identified as typical components of alternative diversion programs for nurses (NCSBN, 2009). Although requests for standards for these programs have come from many sources, no verified best-practice standards exist for alternative programs for nurses or physicians. Research seems to support the success of the common elements of these programs, such as intense, long-term treatment; aftercare; continuing care; evaluation of the many aspects of recovery; and regular, consistent review of progress and compliance with contract stipulations (McLellan, Skipper, Campbell, & DuPont, 2008; Merlo & Gold, 2008). Stipulations may include initial treatment, aftercare, long-term continuing care, the cessation of practice, practice restrictions and stipulations, notification of employers, evaluation of return-to-work practice by on-site supervisors or managers, random drug screens, attendance at 12-step or other support group meetings, work with a peer sponsor, and written or regular face-to-face evaluations of compliance.

Summary

Nurses have specific risk factors for substance abuse disorders related to their professional specialties and their workplace. They also share risk factors with the general population. And because 91.1% of nurses are women, most nurses are susceptible to gender-related risk factors as well.

To address substance use disorders early in their progression with understanding and compassion, we need to know and carefully consider the many risk factors that make nurses vulnerable.

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Continuing Education

Nurse Practice Acts Guide and Govern Nursing Practice

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The practice of nursing is a right granted by a state to protect those who need nursing care, and safe, competent nursing practice is grounded in the guidelines of the state nurse practice act (NPA) and its rules. All nurses have a duty to understand their NPA and to keep up with ongoing changes as this dynamic document evolves and the scope of practice expands. This article reviews the reasons for and the importance of state NPAs and associated rules.

Learning Objectives

- Recall the history of nurse practice acts (NPAs).
- Describe the eight elements of an NPA.
- Discuss disciplinary action, including grounds and possible actions.

Before we permit a new driver to get behind the wheel of a car, we must familiarize her with the laws governing driving. But the laws don't tell the whole story. For example, what is a driver to do when entering an unprotected intersection? What governs the driver's movement into the intersection? How does the driver take into account the conditions of weather, vehicle, and road? What is the driver's level of knowledge and experience? The new driver needs guidance or rules to manage the inherent risks.

In the same way, risks are certain in nursing. Patients are ill; medications and treatments have benefits and side effects; clinical situations are underdetermined, open-ended, and highly variable (Benner, Malloch, & Sheets, 2010, p. 6). Providing nursing care sometimes feels like that unprotected intersection being navigated by the new driver. As with the new driver, education and standards provided by laws designed to protect the public provide guidance in nursing practice.

Nursing requires specialized knowledge, skill, and independent decision making. "The practice of nursing involves behavior, attitude and judgment, and physical and sensory capabilities in the application of knowledge, skills, and abilities for the benefit of the client. Nursing careers take widely divergent paths—practice focus varies by setting, by types of clients, by different disease, therapeutic approach or level of rehabilitation. Nurses work at all points of service in the health care system" (National Council of State Boards of Nursing [NCSBN], 1996, p. 13). A layperson does not necessarily have access to the credentials of a health professional nor can a layperson ordinarily judge whether the care received is delivered according to the standard of care. Because health care poses a risk of harm to the public if practiced by professionals who are unprepared or incompetent, professionals are governed by laws and rules designed to minimize the risk.

Moreover, nurses are mobile and sophisticated and work in a society that is changing and asymmetrical for consumers. The result is that the risk of harm is inherent in the intimate nature of nursing care. Thus, the state is required to protect its citizens from harm (NCSBN, 1996, p. 13). That protection is in the form of reasonable laws to regulate occupations such as nursing. Consequently, these laws include standards for education and scope of practice as well as discipline of professionals.

History of Nurse Practice Acts

Prior to the Industrial Revolution, individuals could evaluate the quality of services they received. Many communities were small, and everyone knew everyone. Basic needs were met mostly by each family, and when people turned to others, they knew the reputations of those who provided services. At that time, anyone could call herself a nurse. However, as technology and knowledge advanced, a variety of people and groups began to provide services (NCSBN, 1996, p. 5). Individuals were no longer good arbiters of the quality of a provider or a service.

Because the United States Constitution does not include provisions to regulate the practice of nursing, the responsibility falls to the states. Under a state's police powers, it has the authority to make laws to maintain public order, health, safety, and welfare (Guido, 2010, p. 34). In addition to the state's need to protect the public, nursing leaders wanted to "legitimize the profession in the eyes of the public, limit the number of people who hired out as nurses, raise the quality of professional nurses, and improve educational standards in schools of nursing" (Penn Nursing Science, 2012).

The first nurse registration law, enacted in 1903 in North Carolina, was written to do just that—protect the title of nurse and improve the practice of nursing. Developing nursing exams and issuing licenses was entrusted to the North Carolina Board of Nursing (UNC TV, 2012). New Jersey, New York, and Virginia passed registration laws that same year. These early acts did not define the practice of nursing, but in 1938, the state of New York did define a scope of practice for nursing (NCSBN, 2010). By the 1970s, all states required licensure for registered and practical nurses.

Advanced practice nurses can be traced to the Civil War, when nurses assisted during surgery with anesthesia services (Hamric, Spross, & Hanson, 2005, p. 4). Advanced practice registered nurse (APRN) roles and specialization have continued to this day as has the evolution of formal scope of practice language within legislative statutes.

Nurse's Guide to Action

How could a law function as a guide to action if almost no one knows it? (Howard, 2011, p. 30). The laws of the nursing profession can only function properly if nurses know the current laws governing practice in their state.

All states and territories have enacted a nurse practice act (NPA). Each state's NPA is passed by the state's legislature. But the NPA itself is insufficient to provide the necessary guidance for the nursing profession. Therefore, each NPA establishes a board of nursing (BON) that has the authority to develop administrative rules or regulations to clarify or make the law more specific. Rules and regulations must be consistent with the NPA and cannot go beyond it. These rules and regulations undergo a process of public review before enactment (NCSBN, 2011a; Ridenour & Santa Anna, 2012, p. 504). Once enacted, rules and regulations have the full force and effect of law.

Although the specificity of NPAs varies among states, all NPAs include:

- definitions
- authority, power, and composition of a BON
- educational program standards
- standards and scope of nursing practice
- types of titles and licenses
- protection of titles
- requirements for licensure
- grounds for disciplinary action, other violations, and possible remedies.

Definitions

For the intent of a law to be useful to legislators and citizens, terms or phrases used in statutes must be clear and unambiguous. Of course, a law does not need to define terms that are commonly understood. However, definitions are often included in laws to avoid uncertainty about the meaning of words. For example, encumbered, reinstatement, and reactivation are often defined in NPAs. An encumbered license is defined as a license with current discipline, conditions, or restrictions. Reinstatement is different from reactivation in that the former refers to reissuance of a license following disciplinary action, whereas the latter is a reissuance not related to disciplinary action (NCSBN, 2012a).

Authority, Power, and Composition of a BON

The NPA gives authority to regulate the practice of nursing and the enforcement of law to an administrative agency or BON that is charged with maintaining the balance between the rights of the nurse to practice nursing and the responsibility to protect the public health, safety, and welfare of its citizens (Brous, 2012, p. 508). The membership and qualifications of the BON, usually composed of registered nurses (RNs), licensed practical/vocational nurses (LPN/VNs), advanced practice nurses, and members representing the public, are specified by the NPA. Specifics regarding terms of office, meetings, and election of officers are also included.

How the membership of the BON is constituted depends on state statute. Some states give the governor authority to appoint members to the BON after reviewing suggestions from professional nursing organizations. Other states require nominations from professional organizations with appointment by the director or head of the regulatory agency. In North Carolina, members of the BON are elected by the general public. In still other states, the legislature appoints public members (Brent, 2012, p. 2). The BON typically hires an executive officer, who has the authority to staff the office with nurses, attorneys, investigators, and administrative staff.

Typically, the powers and duties of BONs include:

- hiring BON employees
- making, adopting, amending, repealing, and enforcing rules
- setting nursing education standards
- setting fees for licensure
- performing criminal background checks
- licensing qualified applicants
- maintaining database of licensees
- ensuring continuing competence
- developing nursing standards of practice
- collecting and analyzing data
- implementing discipline process
- regulating unlicensed assistive personnel.

Educational Program Standards

The BON must set standards for prelicensure nursing educational programs and clinical learning experiences and approve such programs that meet requirements of the NPA. These standards are reflected in the rules that accompany the NPA. The standards for prelicensure programs include accreditation, curriculum specifics, administrator and faculty qualifications, continuing approval, and approval of new, or withdrawal of approved, nursing education programs.

Specific curriculum rules often include necessary standards of evidence-based clinical judgment; skill in clinical management; biologic, physical, social, and behavioral science requirements; professional responsibilities; legal and ethical issues; patient safety; and best practices of nursing.

Standards and Scope of Nursing Practice

One's nursing care is both directed and measured by the NPA and rules. The standards and scope of nursing practice within an NPA are aligned with the nursing process. For example, comprehensive nursing assessment based on biologic, psychological, and social aspects of the patient's condition; collaboration with the health care team; patient-centered health care plans, including goals and nursing interventions, can all be language within the NPA. Further standards include decision making and critical thinking in the execution of independent nursing strategies, provision of care as ordered or prescribed by authorized health care providers, evaluation of interventions, development of teaching plans, delegation of nursing intervention, and advocacy for the patient.

Rules are often more specific than the act. The NPA may require *safe practice*, whereas the rules may specify a plan for *safe practice*, requiring orientation and training for competence when encountering new equipment and technology or unfamiliar care situations; communication and consultation with other health team members regarding patient concerns and special needs, status, or changes; response or lack of response to interventions; and significant changes in patient condition (NCSBN, 2012a, 2012b).

The NPA typically identifies *delegating and assigning nursing interventions to implement the plan of care* as within an RN's scope of practice (NCSBN, 2012a). The rules, however, spell out the RN's responsibility to organize, manage, and supervise the practice of nursing. Indeed, the rules can delineate the specific steps for *effective delegation* by an RN as ensuring:

- unlicensed assistive personnel (UAP) have the education, legal authority, and demonstrated competency to perform the delegated task
- task is consistent with UAP's job description
- task can be safely performed according to clear, exact, and unchanging directions
- results of the task are reasonably predictable
- task does not require assessment, interpretation, or independent decision making
- patient and circumstance are such that delegation of the task poses minimal risk to the patient
- consequences of performing the task improperly are not lifethreatening
- RN provides clear directions and guidelines regarding the task (NCSBN, 2012b).

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Title and Licensure

The use of the title *nurse* by unlicensed individuals misleads and endangers the public. "This poses a serious threat to patient care and safety. Reserving the title *nurse* for only those meeting the legal and educational standards allows the public to consult with professionals required to adhere to professional codes of practice and ethics" (Pennsylvania State Nurses Association, 2011).

NPA language generally includes a statement regarding the title of RN and LPN/VN. By specifying that the title of RN is "given to an individual intended to practice nursing" and LPN/VN is "given to an individual licensed to practice practical/ vocational nursing," the NPA protects these titles from being used by unauthorized persons and therefore protects the public (NCSBN, 2012a).

Each state's NPA also includes statements regarding examination for licensure as RNs and LPN/VNs, including frequency and requisite education before examination and reexamination. Additional requirements of *licensure by examination* typically include:

- application and fee
- graduation from an approved prelicensure program or a program that meets criteria comparable to those established by the state
- passage of the professional examination
- attestation of no report of substance abuse in the last 5 years
- verification of no report of actions taken or initiated against a professional license, registration, or certification
- attestation of no report of acts or omissions that are grounds for disciplinary action as specified in the NPA.

The majority of jurisdictions include criminal background checks as an additional requirement for licensure (NCSBN, 2012c).

Further requirements are included in NPAs for licensure by examination of internationally educated applicants, licensure by endorsement, as well as licensure renewals, reactivation, and continuing education. Endorsement is an approval process for a nurse who is licensed in another state. Obtaining licensure by endorsement often includes prelicensure requirements and verification of licensure status from the state where the nurse obtained licensure by examination (NCSBN, 2012a).

Although statutory language varies from state to state regarding the licensure of APRNs, most states recognize clinical nurse specialist, nurse midwife, nurse practitioner, and registered nurse anesthetist as APRN roles and require certification by a national nurse certification organization. Education and specific scope of practice vary from state to state.

Grounds for Disciplinary Action, Other Violations, and Possible Remedies

The majority of nurses are competent and caring individuals who provide a satisfactory level of care. However, when a problem is experienced with a nurse and the nurse's performance is not acceptable, a complaint may be filed with the BON. The BON, through its statutory authority specified in the NPA, is responsible for review and action regarding complaints. A BON can take formal action only if it finds sufficient basis that the nurse violated state laws or regulations. Each case varies and needs to be considered on its own merits (Brous, 2012, pp. 510–511; NCSBN, 2012d). For an overview of the disciplinary process from receipt of complaint to resolution, see Figure 1.

Disciplinary cases are often grouped into the following categories:

- *Practice-related:* breakdowns or errors during aspects of the nursing process
- *Drug-related:* mishandling, misappropriation, or misuse of controlled substances
- *Boundary violations:* nontherapeutic relationships formed between a nurse and a client in which the nurse derives a benefit at the client's expense (NCSBN, 2009)
- *Sexual misconduct:* inappropriate physical or sexual contact with a client
- *Abuse:* maltreatment of clients that is physically, mentally, or emotionally harmful
- *Fraud:* misrepresentation of the truth for gain or profit (usually related to credentials, time, or payment)
- *Positive criminal background checks:* detection of reportable criminal conduct as defined by statute (NCSBN, 2011b, 2012e).

If a substance use disorder is suspected from the evidence and there is no diversion of medication, BONs may offer the nurse a nondisciplinary alternative-to-discipline program. These programs are not treatment programs–they are monitoring programs. The possibility of avoiding the public notoriety of discipline can be an important factor in breaking through the nurse's denial of substance use disorder and movement to a program that will assist the nurse in retaining her or his license. These programs are designed to refer nurses for evaluation and treatment, monitor the nurse's compliance with treatment and recovery recommendations, monitor abstinence from drug or alcohol use, and monitor their practice upon return to work. Alternative programs work to return nurses to practice while protecting the public. Various models of alternative programs exist, and their use varies among BONs. Some programs provide services via the BON, a contracting agency, a special committee of the BON, or a peer-assistance program of a professional association or a peer-assistance employee program (NCSBN, 2012f).

For all other grounds, the final decision reached by the BON is based on the findings of an investigation and the results of the complaint process. The language used to describe the types of actions available to BONs varies according to state statute.

Figure 1
Board of Nursing Complaint Process

Although terminology may differ, board action affects the nurse's licensure status and ability to practice nursing in the state taking action. BON actions may include the following:

- Fine or civil penalty
- Referral to an alternative-to-discipline program for practice monitoring and recovery support for those with drug- or alcohol-dependence or some other mental or physical condition
- Public reprimand or censure for minor violation of the NPA, often with no restrictions on license
- Imposition of requirements for monitoring, remediation, education, or other provision tailored to the particular situation
- Limitation or restriction of one or more aspects of practice, such as probation with limits on role, setting, activities, or hours worked
- Separation from practice for a period of time (suspension) or loss of license (revocation or voluntary surrender)
- Other state-specific remedies (NCSBN, 2012g).

BON actions are considered public information, and many BONs have determined that it is in the public interest to publicize their actions against nurses' licenses and actions that reinstate licenses. BONs use a variety of methods to communicate this information, including newsletters and websites. Also, federal law requires that adverse actions taken against a health care professional's license be reported to federal databanks. The National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank are two federal databanks created to serve as repositories of information about health care providers in the United States (NCSBN, 2012h).

Being Informed About Your NPA

Ignorance of the law is never an excuse! The NPA is not something one can study in a prelicensure nursing education program and then put aside. The act is a dynamic document that evolves and is updated or amended as changes in scope of practice occur. "Inherent in our current healthcare system are changes which relate to demographic changes (such as the aging of the "baby boomers"); advances in technology; decreasing healthcare dollars; advances in evidence-based healthcare procedures, practices and techniques; and many other societal and environmental factors" (NCSBN, 2012i).

Your state BON is a resource for the NPA. Links to NPAs are available on most state BON websites. Some BONs attempt to provide new information to nurses via their website or newsletter (Tedford, 2011). For example, the Virginia BON posts a list of frequently asked questions to help nurses navigate the various aspects of licensure and posts announcements regarding practice or licensing changes on their homepage (Satterlund, 2012).

The practice of nursing is a right granted by a state to protect those who need nursing care. The guidelines of the NPA and its rules provide safe parameters within which to work and protect patients from unprofessional and unsafe nursing practice (Brent, 2012, p. 5). More than 100 years ago, state governments established BONs to protect the public's health and welfare by overseeing and ensuring the safe practice of nursing. Today, BONs continue their duty, but the law cannot function as a guide to action if almost no one knows about it. "To maintain one's license in good standing and continue practicing, nurses must understand that rights are always accompanied by responsibilities" (Brous, 2012, p. 506). Make sure you know your state's NPA and rules before you enter into that unprotected intersection of nursing care.

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Continuing Education continued on page 10

Continuing Education continued from page 9

Nurse Practice Acts Guide and Govern Nursing Practice
Learning Objectives

- Recall the history of nurse practice acts (NPAs).
- Describe the eight elements of an NPA.
- Discuss disciplinary action, including grounds and possible actions.

The authors and planners of this CE activity have disclosed no financial relationships with any commercial companies pertaining to this activity.

Ce

CE Posttest

Nurse Practice Acts Guide and Govern Nursing Practice
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Contact hours: 1.4
Posttest passing score is 75%.
Expiration: October 2015

Posttest

Please circle the correct answer.

1. Which state was the first to enact a nurse practice act (NPA)?
a. North Carolina
b. New York
c. New Jersey
d. Virginia

2. What is the purpose of an NPA?
a. To protect nurses from lawsuits
b. To protect the public
c. To guide federal health care policy
d. To guide workplace policy

3. Which statement about the regulation of nursing practice is correct?
a. Every state and territory has adopted the same set of rules and regulations for nursing practice.
b. Each state has the authority to enact a law governing nursing practice.
c. The U.S. Constitution includes provisions for regulating the practice of nursing.
d. Professional standards of practice are enacted through regulatory organizations.

4. What is the best resource for information about an NPA?
a. Healthcare Integrity and Protection Data Bank
b. U.S. Department of Health and Human Services
c. State board of nursing (BON)
d. American Nurses Association

5. BON members are:
a. elected officials who serve for 2 years.
b. appointed by the governor.
c. nurses and sometimes members of the public.
d. hired by the BON's executive officer.

6. Some newly licensed RNs are discussing their NPA during orientation. Which statement is *incorrect* and needs to be corrected by their preceptor?
a. The NPA requires certification and a master's degree for all APRNs.
b. The standards and scope of practice for nurses are aligned with the nursing process.
c. The use of the title *registered nurse* is protected by the NPA.
d. The NPA sets standards for prelicensure nursing education.

7. What is the relationship between an NPA and rules or regulations?
a. A BON can enact a rule without input from the public.
b. A BON can change a regulation anytime.
c. Rules can supersede the requirements of an NPA.
d. Rules are often more specific than the NPA.

8. Which of the following is an example of unacceptable delegation?
a. The RN asks the unlicensed assistive person to help a client walk to the bathroom.
b. The RN asks the unlicensed assistive person to measure and then record a client's vital signs.
c. The RN assigns the LPN to care for a client who is ready for discharge.
d. The RN delegates medication administration to the LPN.

9. Which of the following is a requirement for initial licensure as a nurse in every state?
a. Confirmation of being drug free for at least 1 year
b. Passing a licensure examination
c. Criminal background check verifying no arrest record
d. Endorsement by the state of permanent residence

10. A complaint is filed against a nurse. What can the nurse expect to happen next?
a. The complaint will be investigated.
b. The nurse's license will be temporarily suspended.
c. The nurse will have a mandatory reduction in work hours.
d. The nurse will be monitored on the job.

11. After agreeing to participate in an alternative-to-discipline program, a nurse can expect:
a. an announcement of her or his participation in the program in a newsletter.
b. an official letter of censure in her or his workplace records.
c. to return to work with no restrictions.
d. regular monitoring to ensure compliance with treatment.

12. Which type of discipline case involves accepting gifts and money from a client while caring for him or her?
a. Abuse
b. Fraud
c. Boundary violation
d. Practice-related

13. The nurse is renting a house from a former client and, after several months, refuses to pay rent. The former client files a complaint. This is an example of which type of discipline case?
a. Fraud
b. Abuse
c. Boundary violation
d. Practice-related

14. A nurse leaves the long-term care facility building for several hours without telling anyone and without authorization. It is later discovered that the nurse documented providing care and giving medications to residents while she was out of the building. This is an example of which type of discipline case?
a. Fraud
b. Abuse
c. Sexual misconduct
d. Practice-related

15. The National Practitioner Data Bank is:
a. a repository of information about health care providers in the United States.
b. used to keep track of nurses assigned to alternative-to-discipline programs.
c. a method of tracking licensure renewal.
d. available to the general public for finding information about health care providers.

Evaluation Form (required)

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).

- Recall the history of nurse practice acts (NPAs).
  1 2 3 4 5
  _____
- Describe the eight elements of an NPA.
  1 2 3 4 5
  _____
- Discuss disciplinary action, including grounds and possible actions.
  1 2 3 4 5
  _____

2. Rate each of the following items from 5 (very effective) to 1 (ineffective):

- Was the author knowledgeable about the subject?
  1 2 3 4 5
  _____
- Were the methods of presentation (text, tables, figures, etc.) effective?
  1 2 3 4 5
  _____
- Was the content relevant to the objectives?
  1 2 3 4 5
  _____
- Was the article useful to you in your work?
  1 2 3 4 5
  _____
- Was there enough time allotted for this activity?
  1 2 3 4 5
  _____

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Revised CMS Hospital Regulations Address Nursing Barriers

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On May 16, 2012, the Centers for Medicare & Medicaid Services (CMS) published a final rule reforming the conditions of participation, the federal health and safety regulations that hospitals must meet to ensure high-quality care for all patients and to be eligible to receive reimbursement from CMS programs. The final rule was developed through a retrospective review of existing federal regulations called for by President Obama's January 18, 2011, Executive Order 13563 to "modify, streamline, or repeal" regulations that impose unnecessary burdens, including those on hospitals and other providers that must comply with requirements through Medicare. The rule takes into consideration numerous burden-reduction recommendations from hospitals, critical access hospitals, members of Congress, patient advocates, and others. Revisions to the hospital requirements for medical staff, nursing services, and medical records have a direct impact on the way nurses provide care in our nation's hospitals.

On May 16, 2012, the Centers for Medicare & Medicaid Services (CMS) published "Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation; Final Rule" (Centers for Medicare & Medicaid Services [CMS], 2012). These conditions of participation (CoPs) are the federal health and safety regulations hospitals must meet to ensure high-quality care and be eligible for reimbursement from CMS programs. Revisions to the hospital requirements for medical staff, nursing services, and medical records have a direct, positive effect on the barriers to nursing practice in our nation's hospitals.

How Regulations Are Revised

The Social Security Act gives the Secretary of Health and Human Services (HHS) the authority to revise regulations when a need is identified. The need for revisions can come to the Secretary's attention when the public, the CMS administrator, Congress, or the president identifies an issue. Research is conducted and consultation is sought with interested stakeholders to identify evidence-based practices and relevant research. Consultation is conducted with other federal agencies and CMS offices to coordinate policy decisions. A proposed regulation is drafted and cleared through all agencies in HHS and the Office of Management and Budget. The proposed regulation is published in the *Federal Register* to allow for a 60-day public comment period. The Administrative Procedures Act requires that the public have an opportunity to opine on any regulation it will have to comply with. After the 60 days, CMS must respond to all comments and make relevant revisions to the proposed rule based on them before the final rule is published in the *Federal Register.* Responses to the comments received on the proposed rule are incorporated into the final rule. Final rules generally go into effect 60 days after publication. Accrediting organizations must change their standards to reflect the changes in the CMS regulations to ensure that the organizations they accredit are meeting the CMS requirements.

The final regulations reflect the CMS's commitment to the general principles of the president's January 18, 2011, Executive Order 13563, "Improving Regulation and Regulatory Review," to reduce regulatory burden and to reflect current industry standards of practice. The purpose of the Executive Order is to improve the quality of existing regulations consistent with the statute; streamline procedural solutions for businesses to enter and operate in the marketplace; maximize net benefits (including benefits that are difficult to quantify); and reduce costs and other burdens on businesses to comply with regulations.

Revising the CoPs

CMS solicited input from hospitals, health care practitioners, accreditation organizations, patient advocates, professional organizations, members of Congress, and other experts on which CoPs should be revised or eliminated. Using this stakeholder input, CMS published a proposed rule for revisions to the CoPs on October 24, 2011 (CMS, 2011), with the overall intent of increasing the time and resources hospitals and providers can devote to patient care by revising or eliminating outdated, burdensome, and unnecessary regulations. The agency received 1,729 public comments on the proposed rule before the public comment period closed on December 23, 2011. Most comments supported the proposed rule, and many reasonable suggestions for additional revisions and clarifications were offered. CMS revised the proposed regulations based on the public comments and published the final regulations in the *Federal Register* on May 16, 2012 (CMS, 2012). The regulations went into effect on July 16, 2012.

The comments incorporated into the final rule can be classified into three categories: those from hospitals, those from physicians and other practitioners, and those from the general public. The hospital industry and accrediting organizations expressed overwhelming support for the proposals and agreement with efforts to bring the CoPs in line with current practice, eliminate burdensome and obsolete regulations, and provide hospitals with operational flexibility. Physician groups mostly disagreed with the rule's staffing proposals and with what they viewed as CMS's endorsement of replacing physicians with advanced practice registered nurses (APRNs) and nonphysician practitioners. Though nonphysician practitioners supported most of the proposals, they urged further changes that they believe would allow them to practice to the full extent of their education and training under their state laws and regulations.

When revising regulations, CMS takes state laws regarding scope-of-practice issues into account. If, for example, a CMS hospital regulation would state that only physicians may write medical orders, state laws permitting APRNs to write orders in hospitals would be overridden. Because of this, the CoPs often defer to state laws regarding scope-of-practice issues. However, hospitals may establish rules and policies that are more restrictive than federal and

Revised CMS Hospital continued on page 12

Revised CMS Hospital continued from page 11

state laws and regulations as long as their rules and policies do not violate a law or regulation. This final rule allows hospitals more regulatory flexibility because CMS believes hospitals will be encouraged to explore ways to expand their medical staff membership and practice privileges to truly benefit patients. CMS has attempted to reduce barriers to practice in the CoPs, so nonphysician practitioners, such as APRNs and physician assistants (PAs), can practice to the full extent allowed by their state laws.

Key Revisions Affecting Nurses

Nurses and nursing care are essential components of hospital operations, so any change to the regulations governing the delivery of care affects APRNs and registered nurses (RNs) in the hospital environment. The regulation revisions that went into effect on July 16, 2012, will most directly impact the delivery of nursing care by:

- broadening the concept of "medical staff" by encouraging the use of nonphysician practitioners, such as APRNs and PAs, so they may perform to the full extent of their capabilities as defined in their scope of practice
- requiring that all eligible candidates, including APRNs and PAs, be reviewed by the medical staff for potential appointment to the hospital medical staff and allowing for the granting of all the privileges, rights, and responsibilities of appointed medical staff members
- eliminating the 48-hour authentication of verbal orders requirement
- allowing hospitals to use a single, interdisciplinary care plan that supports coordination of care through nursing services
- encouraging the use of evidence-based preprinted and electronic standing orders, order sets, and protocols that ensure the consistency and quality of care provided to all patients, which allows nurses to implement orders that are timely and clear.

Medical Staff Membership

CMS believes that the changes to the medical staff requirements most directly address the CMS-specific recommendations in the report, *The Future of Nursing: Leading Change, Advancing Health* (Institute of Medicine, 2010). One Institute of Medicine recommendation urges CMS to amend or clarify regulations to ensure that APRNs are eligible for clinical privileges, admitting privileges, and membership on a hospital's medical staff.

CMS believes that the interprofessional practice approach to patient care is the best model for hospital patients. Various practitioners such as APRNs have proven themselves to be valuable members of a team in providing efficient, high-quality health care. Patients benefit from interprofessional collaboration because it allows APRNs, physicians, and other practitioners to learn from each other and improve their practices. The savings hospitals will realize from the changes to the medical staff requirements will depend on the extent to which they take advantage of the regulatory flexibility the new requirements afford. Hospitals that view these changes as a means to be more inclusive of APRNs on their medical staffs will most likely reap the most benefits, as will their patients.

Additionally, CMS requires that all eligible candidates who apply for medical staff membership be reviewed by the medical staff for possible appointment. CMS became aware of situations in which APRNs submitted applications to hospitals and did not receive any communication on the status of their submissions. In essence, the application was ignored. CMS expects this revised requirement to eliminate such occurrences and allow APRNs and other practitioners to be considered in an unbiased manner for membership on a medical staff.

Single Interdisciplinary Care Plan

Many hospital care planning processes have evolved into interdisciplinary systems in which interdisciplinary team members document the care and treatments provided by their disciplines. Nurses, however, have been required to develop a separate nursing care plan for every patient and then identify the sections of each nursing care plan that needs to be integrated into the hospital's interdisciplinary care plan (ICP) and transfer the information to the ICP. By allowing hospitals to include the nursing care plan in the ICP for each patient, CMS will save nurses considerable time. CMS believes many hospitals have already developed a system for eliminating this time-wasting step. For those that have not, CMS estimates that doing so can save nurses 9 minutes per hour or 15% of their shift. Eliminating a paperwork requirement allows nurses more time to spend providing patient care.

Authentication and Standing Orders

This final rule eliminated the requirement for verbal orders to be authenticated within 48 hours of the time they are received. Based on CMS experience with hospitals and feedback from stakeholders, CMS believes an RN or a nonnurse trained in order verification checks medical records regularly to ensure compliance. CMS believes the elimination of this requirement can save nurses 1 hour a day.

Before publication of the final hospital regulation, the use of standing orders, order sets, or protocols was not addressed in hospital regulations, although their use was recognized as current practice. The final regulation encourages their use. These grab-and-go orders and protocols will likely increase efficiency and thoroughness in APRN ordering, which will improve the quality of patient care. Additionally, nurses will spend less time interpreting written orders and calling practitioners for clarification or additional orders, which also will allow more time for quality, patient-centered care. This change not only will increase the efficiency of staff nurses but also will allow them to use their judgment and to practice to the full extent of their education and training. Patients benefit from these changes because delays in receiving care and the possibility of medical errors decrease.

Included in the final regulations is a requirement that all standing orders, order sets, and protocols be reviewed periodically and approved by the medical staff, nursing, and pharmacy leadership and that they be consistent with nationally recognized guidelines. The inclusion of nurses in the review and approval process ensures that nursing has input into the orders that they will be implementing on a consistent basis. As with any orders, these orders must be dated, timed, and authenticated by a practitioner who is responsible for the care of the patient. In addition, CMS now allows drugs and biologicals to be prepared and administered on the orders of nonphysician practitioners acting in accordance with their state's laws, scope of practice, and hospital privileges. The use of the term *practitioner* throughout the final regulation is intended to facilitate the hospital's use of APRNs and PAs in the delivery of efficient, interprofessional care.

Moving Forward

Although the final regulation has done much to eliminate barriers to the delivery of care by APRNs within the hospital environment, much work is still needed. CMS will continue to address potential barriers, but the differences between state practice acts must also be addressed. National uniformity in care delivery by APRNs over time may contribute to the development of a comfort zone for hospital administrations and physicians that will more readily allow for the development of cohesive interprofessional teams. CMS looks forward to partnering with all clinicians in improving the care delivered to patients.

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A New Legal Interpretation of Duty for Registered Nurses

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Today, the courts are placing new emphasis on patient safety by recognizing a stricter duty for nurses to evaluate and question medication orders and protocols. Thus, nurses may find that they are more frequently named in civil lawsuits involving medication errors, a safety problem facing nurses in all patient-care settings. In the face of these changes, boards of nursing will need to protect the public and nurses by ensuring that regulations governing nursing practice are consistent with the court's expanded definition of a nurse's duty. This article discusses new challenges to ensuring that regulations governing nursing practice are consistent with the court's definition of a nurse's duty and safe nursing practice.

Registered nurses (RNs) soon may find that the courts are placing an increased emphasis on patient safety by expanding the duty of nurses to evaluate and question medication orders and protocols and, if necessary, to refuse to administer prescribed drugs. In *Applewhite v. Accuhealth Inc.* (2010), the Appellate Division, First Department in New York, held that an RN should not have administered an intravenous (I.V.) steroid in the home setting without having epinephrine available. The court held that the RN had a duty to the patient to withhold the medication because epinephrine was not provided by the home care agency or ordered by the physician, and the nurse was not authorized to prescribe it.

This article discusses this lawsuit in depth and presents new challenges and implications for regulators regarding ensuring that regulations governing nursing practice are consistent with the court's definition of a nurse's duty and safe nursing practice.

The Incident

Accuhealth, a home infusion agency in New York City, was directed by an ophthalmologist to provide methylprednisolone (Solu-Medrol) I.V. to a child suffering from a serious eye infection. The agency followed its usual I.V. infusion protocol and sent the medication and necessary administration equipment to the patient's home by mail. The ophthalmologist's prescription specified three doses on 3 consecutive days for 3 months. The first month, the home infusion nurse administered the three doses without incident. The patient showed no signs or symptoms of a reaction. When the nurse administered the first of three doses for the second month, however, the patient had an anaphylactic reaction. What happened next is in dispute, though the outcome is not: The child sustained serious brain damage.

Charges Filed

The family sued the agency that prepared the drug administration kit and the nurse who administered the drug. The family did not name the ophthalmologist who prescribed the methylprednisolone. Both Accuhealth and its insurance company went bankrupt, leaving the nurse as the only solvent defendant.

While the family charged the nurse with professional malpractice, they did not file a complaint with the New York board of nursing. The charge asserted that she failed to properly supervise and attend to the patient, failed to properly and immediately perform cardiopulmonary resuscitation (CPR), failed to advise the 911 operator regarding the nature of the emergency, and failed to ensure that epinephrine was available to counteract the anaphylaxis. During depositions, the nurse said that she immediately ended the drug infusion, began CPR, and asked the patient's mother to contact emergency responders. The mother stated that the nurse was not in the room when the reaction began, thereby delaying the response to her daughter's distress. She also testified that the nurse did not end the infusion immediately when her daughter became symptomatic and that the nurse began CPR on the couch, rather than moving the patient to the floor or another firm surface.

The following facts were undisputed:

- The home infusion agency provided the drug administration kit, which did not include epinephrine.
- The kit included only the prescribed drug, methylprednisolone, and the devices needed to administer it.
- Anaphylaxis is a known reaction to methylprednisolone.
- New York law does not allow an RN to carry epinephrine without a patient-specific prescription or a provider order for a non-patient specific protocol (New York State Education Law, 2012).
- Without a prescription or provider order, the nurse did not have access to epinephrine.

After these pretrial depositions, the nurse's attorney moved for a summary judgment, requesting that the court dismiss all claims against her. To support this motion, the defendant presented a trauma center RN as an expert witness who opined that the home transfusion nurse was not authorized to carry epinephrine without a physician's prescription and that it would have been a violation of good and accepted nursing practice for the nurse to obtain the drug and administer it on her own without a prescription *(Applewhite v. Accuhealth Inc., 2010).*

In opposing the defendant's motion, the plaintiff produced affidavits from two experts. An I.V. home infusion RN nurse from Georgia attached the drug monograph for methylprednisolone to her affidavit. The monograph described anaphylaxis as an adverse effect and advised anyone administering the drug to have epinephrine immediately available. This expert stated that the defendant failed to meet the national standard of care for infusion therapy by failing to have the requisite knowledge about the drug and failing to ensure the presence of epinephrine in the home when she administered the drug. Although the Infusion Nurses Society has published standards of practice since the 1980s (Infusion Nurses Society, 2011), only one article written by the witness was provided to define the national standard of care. The second expert witness, a physician, testified that the defendant was responsible for handling any complications of the drug administration and that if she was not prepared for the reaction, she should not have administered the drug.

The court denied the request for dismissal and ruled the case should go to trial.

The Appeal

The defendant appealed the decision. Before the appeals court, the central issue argued by the plaintiff was that the nurse had a duty to her patient to withhold methylprednisolone because she did not have epinephrine available and therefore was unprepared to treat the reaction, a known adverse effect.

The appeals court, in a three-to-two opinion, held that the nurse committed malpractice when she administered the drug without epinephrine on hand, knowing that anaphylactic shock was a possible reaction.

Majority Opinion

The majority held that a nurse in the home setting with no readily available backup was required to ensure that all reasonably foreseeable problems could be addressed to minimize patient harm. According to the majority, the contemporary model of nurses as proactive partners with "reasonable directives of doctors they work with" (*Applewhite v. Accuhealth Inc.,* 2010, p. 104) required the nurse to withhold the drug without epinephrine available. Thus, the nurse could be held liable for malpractice, even without evidence that the prescribing physician or the home infusion industry required epinephrine. The nurse's duty to inquire about the availability of epinephrine before proceeding with the infusion "simply recognizes the critical role of nurses as a check against medical error" (*Applewhite v. Accuhealth Inc.,* 2010).

The majority stated that its decision did not create a new duty for RNs or require RNs to have the same pharmaceutical skills as physicians and advanced practice registered nurses (APRNs). According to the majority, epinephrine as a treatment for anaphylaxis is "widely known to laypeople" and administering the drug "is far from a radical procedure" (*Applewhite v. Accuhealth Inc.,* 2010).

The majority also rejected the argument that the nurse could not be held liable for breaching the standard of care in the industry, even though there was no evidence indicating that the standard of care in home infusion therapy required epinephrine or that physicians routinely ordered epinephrine to be dispensed with home infusion drugs:

> The idea of having a dose of epinephrine available in cases where, as here, a person may encounter a substance known to cause anaphylaxis, is so obvious that common sense would seem to dictate that it be routine. Indeed, it is so intuitive, even to a layperson, that the antidote for anaphylaxis should accompany a medicine known to cause anaphylaxis, that lack of empirical proof that this "recommendation" is "followed" by the medical community should hardly compel the dismissal of the complaint. This is especially true in this case, where the defendant has not offered any plausible reason why a physician would not prescribe epinephrine for use by a home infusion nurse if, in her role as "coordinate[r of] the delivery of... patient services" the nurse suggested that it was medically indicated. (*Applewhite v. Accuhealth Inc*., 2010, p. 103)

Minority Opinion

The dissenting opinion held that the court should not impose duties on nurses that belong by statute to physicians. The minority argued that a new legal duty for RNs should be imposed by the state legislature through statute or regulation, not by the court.

The dissent reviewed the conclusion that the plaintiff established epinephrine was a standard of care and routinely available in home infusion therapy based on a single publication cited by the plaintiff's expert. The minority noted that an expert witness can establish the standard of care for a nurse and the courts can derive the scope of a professional's duty from expert testimony and publications, but stated, "However, where, as here, statutes define and limit the parameters of the professional's responsibilities in a particular area, courts should hesitate to use their authority to impose, through case law, duties previously not contemplated by the controlling statutory authorities" (*Applewhite v. Accuhealth Inc.*, 2010, p. 110).

In support of this argument, the dissent noted that the RN could not legally possess epinephrine without a prescription and could not legally dispense it without an order from an APRN or physician. The majority, according to the minority, imposed a new duty for nurses "not within nurse's statutorily defined sphere of responsibility" and:

> A new duty of inquiry would blur the line between physicians and nurses, and substantially extend the responsibilities of registered professional nurses. Indeed, it cannot be reconciled with the long-standing rule that nurses are normally protected from liability if they are merely following a physician's orders, except where the physician's orders are clearly contraindicated by normal practice. (*Applewhite v. Accuhealth Inc*., 2010, p. 112)

The dissent noted that New York's highest court, while acknowledging the expanded scope of nursing practice, never suggested that nurses should act as de facto supervisors of prescribing physicians.

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A New Legal Interpretation continued from page 13

The dissent also held that the RN defendant's expert could testify concerning drug therapies and anaphylaxis shock because, even though she was not a home infusion specialist, "any registered nurse with hospital experience would be qualified to testify on the issue of the standard of care relevant to an anaphylactic patient" (*Applewhite v. Accuhealth Inc.,* 2010, p. 113). The two dissenting judges noted that no court in New York ever addressed the standard of care for a nurse who specialized in a field for which New York does not issue advanced certification. The dissent concluded that the home infusion therapist might be subject to a "heightened specialized standard of care" (*Applewhite v. Accuhealth Inc.,* 2010, p. 114), but that even under that higher standard, allowing the claim to go forward against the nurse for failing to arrange for epinephrine when the prescribing physician was not even named a defendant in the case would be unfair. The dissent added a cautionary note:

> The use of home infusion therapy to administer powerful medications, rather than administering them in a hospital setting where crash carts and antidotes are at hand, certainly has many cost benefits and personal benefits to the patient. But, if plaintiffs are correct, and such powerful medications are accompanied by a substantial possibility of a life-threatening adverse reaction, the medical profession and our society in general ought to reconsider the advisability of employing home infusion therapy without providing the medical provider administering the infusion with at least an EpiPen to combat such a reaction. (*Applewhite v. Accuhealth Inc.*, 2010, p. 115)

Case Law: Duty to Inquire

More than two decades earlier, New York's highest court held that "the role of the registered nurse" has changed from "a passive servile employee to that of aggressive decisive healthcare provider" (*Bleiler v. Bodnar*, 1985). In *Applewhite v. Accuhealth Inc.,* the court decided that the nurse, who had a chance to inquire about the availability of epinephrine, was a "critical backstop" to preventing a serious injury.

In 1968, the Court of Appeals recognized that when an attending physician gives direct, explicit orders to the hospital staff, nurses are not authorized to determine the proper course of medical treatment except "where the hospital staff knows that the doctor's orders are so clearly contraindicated by normal practice that ordinary prudence requires inquiry into the correctness of the orders" (*Toth v. Community Hospital at Glen Cove*, 1968). This opinion established a legal duty for nurses: If a physician's orders are clearly contraindicated by normal practice, a nurse has a duty to question the correctness of the orders. However, before *Applewhite v. Accuhealth Inc.,* New York courts never considered this duty outside of the hospital setting.

Also, the duty to inquire is based on "normal practice." In *Applewhite v. Accuhealth Inc.,* no evidence was presented to show that normal practice required epinephrine to be available. Expert testimony indicated that epinephrine should have been available, but no witness offered evidence that epinephrine was available to home infusion nurses from Accuhealth or any other New York area home infusion company. In fact, the evidence was to the contrary: The defendant testified that in her 19 years in the home infusion industry, she had never received epinephrine in the kit.

The court's recognition of a duty to inquire in *Applewhite v. Accuhealth Inc.* is similar to findings by courts in other states. In Ohio, an RN was required to inquire about her patient's use of antiseizure medications (*Hitch v. Ohio Department of Mental Health,* 683 N.E. 2d 38 (Ct. App. Ohio 1996). In Louisiana, a nurse had a duty to inquire and contact a prescribing physician if she had doubts about any prescription (*Norton v. Argonaut Ins. Co.,* 144 So. 2d 249 (La. App. 1st Cir. 1962), *cited in Gassen v. East Jefferson General Hospital*, 628 So. 2d 256 (La. Ct. App. 5th Cir. 1993). However, the duty to inquire articulated in *Applewhite v. Accuhealth Inc.* is broader than the duty articulated in these states. The New York court's concept of duty requires the nurse not only to inquire but also to decline to administer a prescribed drug unless other prophylactic measures are available.

Analysis: Expanding Role, Expanding Liability

The reverberations of this case in the nursing profession are substantial. No current practice standards require that epinephrine or other drugs that treat reactions to be routinely available during home infusion. Though the majority suggested that the public is familiar with the EpiPen, New York State regulations (New York State Education Law, 2012) forbid anyone from possessing epinephrine without a patient-specific prescription or a provider ordered standing protocol. In *Applewhite v. Accuhealth Inc.,* the RN would have needed an epinephrine prescription for the patient. She was not authorized to carry any form of epinephrine, including an EpiPen, to use on an as-needed basis.

The consequences of creating an expanded legal duty for RNs are not confined to the facts of *Applewhite v. Accuhealth Inc.* or the state of New York. The doctrine announced in *Applewhite v. Accuhealth Inc.* is a common law precept, not dependent on any specific New York state statute or regulation. The practice standards for RNs are changing across the United States. The expanded skills and responsibilities of RNs in New York expressed by the appellate division in *Applewhite v. Accuhealth Inc.* and by the court of appeals in *Bleiler v. Bodnar* (1985) are consistent with those in other states. The common law duty announced in *Applewhite v. Accuhealth Inc.* could easily now be imported by skilled personal injury lawyers in other states.

Concurring Federal Ruling

The majority opinion regarding the expanded duty of nurses finds further support in at least one other source, although not cited by the court. In *Berry v. Peterman* (2010), a patient persistently complained of pain to his nurse, but the nurse did not consult a physician. The patient accused the nurse of deliberate indifference. The court held that the nurse could be held liable because he "had the ability to contact [a physician] or other supervisory personnel to voice concerns about the [physician's treatment] of the patient." The nurse could not use the physician's supervisory role to excuse the charge of indifference to his patient's pain. The Court cited the American Nurses Association (ANA) *Code of Ethics* as the basis for this expanded scope of the nurse's duty to her patient (*Berry v. Peterman*, 2010). The *Berry v. Peterman* decision is not factually analogous to *Applewhite v. Accuhealth Inc.* but its holding that a nurse may not defer to a physician's judgment is consistent with the majority opinion in *Applewhite v. Accuhealth Inc.*

The *Berry v. Peterman* court's view of the nurse's need to "take appropriate action" and contact other professionals is backed by the ANA *Code of Ethics*, which discusses the nurse's role as patient advocate (American Nurses Association, 2012). It seems likely that other courts, faced with a nurse failure to challenge a physician's treatment, may move in the same direction.

In adopting the ANA *Code of Ethics* standard as the touchstone for the nurse's duty, the *Berry v. Peterman* court may have also hastened a resolution of the lingering question of whether national or local standards of care should be applied to malpractice claims against nurses. The court embraced a national standard and never considered state standards of care by RNs. Simply put, the Appellate Division in *Applewhite v. Accuhealth Inc.* is not the only authority for an expanded role for nurses as backstops in the health care system. The decision in *Berry v. Peterman*, by a federal court with a wider geographic scope than the New York appeals court, heralds the coming of an expanded legal duty and higher standards of care for nurses throughout the country and the expansion of the legal duty of nurses in all settings, not just home infusion therapy.

Legal Duty to Anticipate Harm

Nurses are legally responsible for inquiring and challenging medical care and orders. When an APRN or physician errs in writing a prescription, the RN has a legal duty to inquire if he or she detects or suspects anything reasonably foreseeable that might injure the patient. The RN's knowledge of complications from medications needs to be detailed and accurate. Consequently, a distinct possibility exists that future liability will be based not only on what the nurse actually knows but also on what she should have known. Because anaphylactic shock is a foreseeable consequence of several I.V. drug therapies, home health agencies, prescribers of home infusion drugs, and RNs who provide the infusion should insist on epinephrine being available at the time of infusion. The courts are likely to use this "must anticipate harm to the patient" standard as the legal duty in all areas of nursing practice.

This expanded legal duty may also affect hospitals, the most frequent employer of RNs. Before *Applewhite v. Accuhealth Inc.*, a hospital could not be held liable if the nurse failed to challenge a physician's order unless it was "clearly contraindicated by normal practice." *Applewhite v. Accuhealth Inc.* lowers that standard of proof by making the RN the legal backstop for physicians and not requiring proof that a decision was clearly contraindicated by a normal practice. In the wake of *Applewhite v. Accuhealth Inc.* and *Berry v. Peterman*, all employers of nurses may face liability for the failure of nurses to question and inquire about physician orders. In the past, a hospital could shift its liability to the provider's failure to prescribe proper medications. Now, a hospital may find that the nurse's liability affects the hospital. Thus, hospitals need to redouble their efforts to update all RNs on medications, their adverse reactions, and the protocols for minimizing reactions.

Significance for Nursing Regulation

Under this expanding legal standard, RNs are more likely to be sued individually when they are involved in medication error cases. Injured plaintiffs will cite *Applewhite v. Accuhealth Inc.* and *Berry v. Peterman* for the nurse's legal duty to review and inquire about prescriptions and other orders. Cases settled by legal counsel representing both the hospital or agency and the nurse may not prioritize the rights of the nurse.

Applewhite v. Accuhealth Inc. and *Berry v. Peterman* also usher in another personally challenging consequence for regulators. Although no action was taken against the nurses license since no complaint was ever filed with the board, if an RN is sued using the *Applewhite v. Accuhealth Inc.* duty, the Office of the Professions may review the RN's actions for professional misconduct. *Applewhite v. Accuhealth Inc.* does not change state law on RN professional misconduct, but it creates a possibility that state licensing agencies may utilize the expanded nursing legal duties in investigations of nursing conduct.

Applewhite v. Accuhealth Inc. may also serve as a caution to nurses who provide home infusion therapy and inject drugs as a part of their responsibilities.

The implications of these cases pose another question: Should a nurse who fails to inquire and causes harm to a patient bring legal action against the physician for failing to include the necessary emergency drugs in the administration kit? *Applewhite v. Accuhealth Inc.* may spawn cross-claims and third-party actions against physicians who make medical errors or fail to foresee the consequences of medication orders. The RN's liability may be offset by the liability of other health care providers, including the physician or APRN who wrote the initial order. This question of the apportionment of liability was not addressed in *Applewhite v. Accuhealth Inc.* because the plaintiff did not sue the physician who wrote the order. However, a nurse's failure to act as a backstop can only result in harm when a physician or APRN errs in writing or failing to write a prescription. Thus, the RN may have a valid claim regarding the apportionment of liability.

Need for Nursing Involvement

As the courts look to the profession for guidance on the concept of duty and the standard of care, organizations such as the ANA and the boards of nursing may have greater roles in defining professional duties and scopes of practice, ensuring that legal concepts are consistent with safe, skilled nursing practice. If in the *Applewhite v. Accuhealth Inc.* and *Berry v. Peterman* cases, the BON had the opportunity to apply standards of care applicable to the circumstances, the parties or the courts could have used these standards and looked to the BON for guidance.

With *Applewhite v. Accuhealth Inc.* and *Berry v. Peterman,* defining expanded duties for nurses and raising the standard of care have just begun. With the national emphasis on patient safety and quality outcomes, expanded liability exposure, higher practice standards, and the need to better coordinate and communicate with other professionals in health care will have a significant impact on future nursing practice.

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Disciplinary Actions**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases. To view the Board's Order or Settlement Agreement for a particular Licensee, please go to NURSYS.com.

CENSURE

Kaleikau, Liane M.
Kansas City, MO
Registered Nurse 098592
On November 1, 2010, in the State of Michigan, 6th Judicial Circuit Court in the County of Oakland, Licensee entered a plea of guilty to the offense of maintaining a drug house.
Censure 11/29/2012 to 11/30/2012

Jens, Dorothy Ann
Humansville, MO
Licensed Practical Nurse 2009025624
On April 29, 2011, Certified Nursing Assistant, D.J.F., saw resident M.W. fall on the floor and hit her head on the base of the table. Licensee completed an assessment of M.W. Licensee did not document the fall or the assessment she performed in M.W.'s chart. D.J.F. asked Licensee if he needed to complete a witness statement. Licensee told D.J.F. that the resident was not hurt so he did not need to complete the statement form. When the facility confronted Licensee about the fall, Licensee denied that the resident had fallen. On March 15, 2010, Licensee received a verbal warning regarding not performing work assignments as a charge nurse, not performing rounds, and not doing monthly summaries. On April 14, 2010, Licensee received a written warning regarding not performing work assignments of the charge nurse. On June 14, 2010, Licensee received a written warning regarding not performing charge nurse duties per policy and procedure. On August 12, 2010, Licensee received a written warning. Licensee did not provide treatment per physician's orders on August 8 and 9, 2010, but Licensee documented that she had done the treatments. On January 17, 2011, Licensee received a written warning regarding administration of medication to a new admission.
Censure 10/30/2012 to 10/31/2012

Garles, Teresa Ann
Gravois Mills, MO
Registered Nurse 2006009541
Several physician orders on a patient's chart had not been signed by the physician. Licensee signed the physician's initials to a medication and protocol order.
Censure 10/19/2012 to 10/20/2012

Kelly, Stephen Michael
Fullerton, CA
Registered Nurse 2010040082
On August 18, 2006, the Texas State Board of Nursing issued an Order disciplining the registered professional nursing license of Licensee for drug diversion in the State of California from 2004.
Censure 11/29/2012 to 11/30/2012

McMahon, Danielle Jordan
Kearney, MO
Licensed Practical Nurse 2010038710
M.A., a patient was discharged on August 25, 2011. On September 1, 2011 the facility received reports that there were photos of Licensee and M.A. on Licensee's Facebook page. An internal investigation was done into Licensee's involvement with M.A. Licensee admitted to staff that she dated the patient M.A. after his discharge. Licensee denied dating him while he was a patient but admitted being attracted to him when he was a patient. The staff stated M.A. called Licensee his girlfriend prior to his discharge. Licensee spent a majority of her time when she was on duty with M.A. and would pass notes and drawings with him.
Censure 11/07/2012 to 11/08/2012

Prestage, Sherry G.
Ballwin, MO
Licensed Practical Nurse 053644
Licensee worked from June 1, 2010 through July 13, 2012, on a lapsed license.
Censure 11/21/2012 to 11/22/2012

Reese, Mary E.
Saint Louis, MO
Licensed Practical Nurse 041557
Licensee worked with an expired license from May 2010 until April 12, 2012.
Censure 11/29/2012 to 11/30/2012

Green, Marissa Halcyone
Florissant, MO
Licensed Practical Nurse 2005038115
On December 10, 2007, while Respondent was on duty, she was observed sleeping in a room at the facility in a resident's recliner, with a sheet pulled up across her chest.
Censure 09/26/2012 to 09/27/2012

Hoberock, Lori Ann
Springfield, MO
Registered Nurse 138250
On January 19, 2011, Licensee removed two Tylenol #3 belonging to a resident from the medication cart and took them for pain. Licensee believed the Tylenol #3 was regular Tylenol. When the narcotic count was off at the end of her shift, she remembered reaching into the drawer and taking what she thought was regular Tylenol and admitted that she had taken the Tylenol from the medication cart for personal use.
Censure 11/14/2012 to 11/15/2012

Butts, Wanda R.
Saint Louis, MO
Registered Nurse 069580
Respondent failed to call NTS on one (1) day. Further, on July 10, 2012 and August 7, 2012, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on two separate occasions, June 4, 2012 and July 26, 2012, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. On June 4, 2012, the low creatinine reading was 9.1. Respondent's creatinine reading was 14.9 for the July 26, 2012, sample.
Censure 09/18/2012 to 09/19/2012

PROBATION

Higgins, Gary Sean
Fort Scott, KS
Registered Nurse 2006023276
Licensee had trouble staying awake during a staffing meeting and often had his head on his desk, was tired and seemed depressed. After Licensee's employment with his employer ended, the employer identified problems with Licensee's record keeping, including:
a. On November 8, 2009, Licensee withdrew medication at 12:56 p.m. and documented the administration of this medication without a written and signed physician order.
b. On November 30, 2009, Licensee withdrew medication for a patient after the patient had been discharged. On November 30, 2009, Licensee withdrew medication and failed to properly document the administration or waste of this medication.
c. On November 30, 2009, Licensee withdrew medication, without a written and signed physician order, for a patient after the patient had been discharged.
d. On January 10, 2010, Licensee withdrew and documented the administration of medication for a patient after the time the patient was discharged.
Probation 11/29/2012 to 11/29/2013

Perry, Jessica Leigh
Columbia, MO
Licensed Practical Nurse 2004012468
On September 25, 2011, resident F reported that she had requested her tube feeding from Licensee on two (2) separate occasions and Licensee had not provided either feeding. Resident F is alert and oriented. Licensee documented that she administered two cans (480 cc) of tube feeding. Licensee admitted to the Director of Nursing that she had not administered the tube feedings. Licensee could not explain why she documented giving the feedings. On September 24, 2011, Licensee documented administering resident D's tube feeding on two (2) occasions. The nurse from the previous shift had left everything needed to administer resident D's tube feeding in resident D's room and nothing had been removed or altered when she resumed her shift after Licensee's shift ended. The security camera tape was reviewed by the Administrator and Assistant Director of Nursing, which revealed that Licensee had not entered the Central Supply room for feeding supplies the entire shift and did not go into the resident's room during her shift. Licensee did not change the dressing on resident W. on September 24, 2011. The next shift found the dressing with the date of September 23, 2011 on it. Licensee initialed on September 24, 2011 that she completed the dressing change. When the director of nursing spoke with Licensee she stated that she initials all of the TARs in advance and she ran out of time to do the dressing change and forgot to go back and circle her initials to indicate the dressing change was not done.
Probation 10/30/2012 to 10/30/2013

Leenerts, Dorothy V.
Payson, IL
Licensed Practical Nurse 053892
On May 10, 1982, Licensee pled guilty to theft. On August 31, 1984, Licensee pled guilty to burglary. On October 25, 1985, Licensee's probation was extended for an additional year due to violating the terms and conditions of her probation by committing the offense of fighting. On July 17, 1992, Licensee pled guilty to domestic battery. On April 17, 1997, Licensee pled guilty to obstructing a peace officer. On March 4, 1999, Licensee pled guilty to unlawful possession of cannabis. Licensee failed to disclose her pleas of guilt on her application for renewal. Licensee further attempted to mislead this Board by stating that she could not obtain copies of her pleas of guilt in the above referenced criminal cases because the court did not retain copies of the documents; however, the Circuit Court of Adams County, Illinois did in fact have the documents which were eventually provided to the Board after three (3) requests from the Licensee.
Probation 10/29/2012 to 10/29/2013

Richmond, Maggie Lynn
Columbia, MO
Registered Nurse 2012034696
On August 28, 2009 Licensee pled guilty to Class B Misdemeanor Property Damage 2nd Degree in the Circuit Court of Dent County. On May 27, 2011 Licensee pled guilty to Class B Misdemeanor of Property Damage 2nd Degree in the Circuit Court of Boone County.
Probation 10/01/2012 to 10/01/2014

Bryant, George A.
Sausalito, CA
Registered Nurse 2005019124
On June 5, 2010, Licensee called in an order for hydrocodone for a personal friend. The friend did not have a valid order for hydrocodone. On June 24, 2010, Licensee called in an order for hydrocodone for himself. On both occasions, Licensee used the name and DEA number of a doctor at the hospital. Licensee did not have authorization to use the doctor's name or DEA number. Licensee voluntarily entered a drug rehabilitation treatment program after the above incidents.
Probation 09/06/2012 to 09/06/2015

Schlette, Tamara Lynn
Saint Charles, MO
Licensed Practical Nurse 2000152456
Licensee had twenty-seven (27) narcotic PRN medication errors. O.B. had an order for Hydrocodone/APAP 7.5.500 one tablet every four hours PRN. On August 22, 2011, Licensee signed out one tablet as administered at 0630, then signed out an additional dose given at 0800. This exceeds the physician order. P.G. had an order for Hydrocodone/APAP 5/325mg 1-2 tablets PO every six hours as needed for pain. On August 8, 9, 10, 12, 13, 14, 15, 17, 18, 19, 22, and 23, 2011, Licensee signed out two tablets at 0800 and 1200. This exceeds the physician's order. M.B. had an order for Percocet 5/325mg 1-2 tablets PO every four hours PRN. On August 12, 2011, Licensee signed out two tablets at 0900; three tablets at 1300; and one tablet at 1400. Licensee did not document the amount of pain or the effectiveness of the pain medication and this exceeds the physician's order. On August 15, 2011, Percocet had been signed out as given at 0500. Licensee signed out two tablets at 0700. This exceeds the physician's order. P.B. had an order for Hydrocodone/APAP 5.325mg 1-2 tablets PO every six (6) hours PRN. On August 8, 9, 10, 12, 13, 14, 15, 18, 19, 22, and 23, 2011, Licensee signed out two (2) tablets at 0800 and 1200. This exceeds the physician's order. All of the above medications were signed out of the Controlled Drug Record, but were not documented as administered on the Medication Administration Record (MAR) nor were these medications documented as wasted.
Probation 11/13/2012 to 11/13/2014

Riley, Treasa A.
St Joseph, MO
Licensed Practical Nurse 028322
Licensee resigned in lieu of termination on November 7, 2011 for practicing outside the scope of practice of a licensed practical nurse, misappropriation of clinic resources, and employee misconduct.
Probation 11/17/2012 to 11/17/2014

Remington, Kim L.
Hillsboro, MO
Registered Nurse 123952
Respondent was required to completely abstain from the use or consumption of alcohol in any form. On June 19, 2012, the Board received the chemical dependency evaluation submitted on Respondent's behalf. The evaluation was completed on June 13, 2012. Respondent reported to the counselor that she last consumed alcohol eight (8) days ago, on June 5, 2012, just thirteen (13) days after meeting with the Discipline Administrator about her requirements. The Board did not receive an update from a chemical dependency professional or proof of attendance in an outpatient treatment program by the first documentation due date of August 7, 2012. The Board did not receive proof of attendance at AA meetings or any other support group meetings by the first due date of August 7, 2012.
Probation 10/15/2012 to 05/07/2017

Smith, Cathy Lin
Centerview, MO
Registered Nurse 2003002349
On July 4, 2011, a pharmacist working with a patient noticed that within seven hours, Licensee removed six doses of Dilaudid for a patient, when the most he should have been given in that time period was three doses. The pharmacist then reviewed Licensee's medication documentation and removal of controlled substances from the medication dispenser. The pharmacist discovered the following:
Over a two-week period, Licensee removed greater than 30 doses of Dilaudid and only three other doses of any other controlled substance.
Licensee's documentation of Dilaudid dispersed to patients did not match actual amounts of Dilaudid removed.
Licensee had greater than 100 Dilaudid pulls each month for the months of March, May, June, and July 2011. No other nursing or anesthesia providers had more than 20 Dilaudid pulls during this time period.
On June 29, 2011, Licensee clocked in at 0635 and out at 1925. Licensee removed Dilaudid for patient RP at 1928, after she had already clocked out. On June 30, 2011, Licensee clocked in at 0637 and out at 1450. Licensee removed Dilaudid for patient RP at 0640. Licensee would not have received a report or assessed her patients within three minutes of clocking in for work. On July 1, 2011, Licensee clocked in at 0633 and out at 1813. Licensee removed Dilaudid for patient RP at 0637. Licensee would not have received a report or assessed her patients within four minutes of clocking in for work. On July 2, 2011, Licensee was called in to do a peripherally inserted central catheter (PICC) placement on patient JD. License clocked in at 1501 and removed Dilaudid for JD at 1507. It is neither necessary nor normal procedure to give Dilaudid for a PICC placement. On July 2, 2011, Licensee clocked out at 1835. Licensee removed Dilaudid for patient JP at 1837, after she had clocked out. On July 4, 2011, Licensee clocked in at 0637 and removed Dilaudid for patient JD at 0639; Licensee would not have received a report or assessed her patients within two minutes of clocking in for work.
Probation 10/30/2012 to 10/30/2014

Abt, Heather Renee
Sainte Genevieve, MO
Registered Nurse 2012037675
Licensee graduated from a Jefferson College's registered nursing program on May 14, 2011. Licensee failed the registered nurse NCLEX on June 6, 2011. On June 7, 2011, the Missouri State Board of Nursing sent Licensee a letter to last address available to the Board informing her that she failed the NCLEX and that she was not eligible to practice as a graduate or registered nurse. Licensee submitted an application to re-take the NCLEX on August 26, 2011. Licensee failed the NCLEX-RN on October 12, 2011. On October 13, 2011 the Missouri State Board of Nursing sent Licensee a letter to the last address available to the Board informing her that she failed the NCLEX and she was not eligible to practice as a graduate or registered nurse. Licensee submitted an application to re-take the NCLEX-RN on January 24, 2012. Licensee was hired on September 2011 as a graduate nurse at a

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graduate nurse salary. Licensee represented herself to the Facility as a graduate nurse who had not yet taken the NCLEX-RN. On October 22, 2011, the Facility became aware that Licensee had not passed her NCLEX-RN. The Facility offered Licensee continued employment at a licensed practical nurse pay. Licensee practiced as a graduate nurse from September 25, 2011 to November 6, 2011 without having passed her NCLEX-RN.
Probation 10/31/2012 to 10/31/2014

Edwards, Laurie A.
West Plains, MO
Registered Nurse 123719
On or about December 12, 2005, Licensee was transported to the emergency department. In Licensee's possession was one bottle containing 35ml of Diprivan 100ml. Licensee had injected herself with 5ml of Diprivan from the bottle. Licensee failed to properly dispose of Diprivan while on duty. Licensee also reported injecting herself with insulin. Within one week after being released, Licensee had similar misconduct and was taken to the emergency department.
Probation 10/11/2012 to 10/11/2015

Morrissey, Erin K.
O' Fallon, MO
Registered Nurse 123377
Suspended 4/5/2012 to 10/5/2012; Probated from 10/6/2012 to 10/6/2017
In September 2010, Licensee removed narcotics for patients in the recovery room at SJMCH who were not assigned to her care contrary to policy and below the standard of care for a nurse. Licensee removed the narcotics for those patients hours prior to the patient arriving in the recovery room contrary to policy and below the standard of care for a nurse.
Following the September 2010 investigation into these issues, Licensee admitted to the diversion of Morphine and Fentanyl, both controlled substances, for her own use. Licensee diverted the controlled substances for three or four months preceding the September 2010 investigation. As a result, Licensee entered out patient drug addiction treatment at CenterPointe Hospital.
In June 2011, the facility conducted an investigation into the controlled substance medication administration by Licensee as a result of Licensee's repeated presence on the Proactive Diversion Reports. The investigation also revealed that Licensee's total administrations of controlled substances for the month of May 2011 was 241 while most nurses ranged between 70 and 126 administrations. For the month of July, Licensee had 584 administrations and the next closest nurse's administration was 236. For the month of August, Licensee had 825 administrations and the next closest was 258. The investigation revealed that for the period June 23, 2011 to July 28, 2011, Licensee was more than plus-3 standard deviations above the mean for the hospital for the removal of Hydromorphone, Fentanyl, and Morphine from the Pyxis system. For the period July 28, 2011 to August 25, 2011, Licensee was again more than plus-3 standard deviations above the mean. Upon cleaning out her locker at her termination, the facility discovered multiple bottles of narcotics (controlled substances) in her locker including four vials of Morphine, 10 mg/ml; seven vials of Fentanyl, 50 mg/ml; one vile of Ondansetron, 4 mg/2 ml), three ampules of Demerol, 50 mg/ml and five ampules of Hydromorhone, 1 mg/ml. There were also nine open syringes in her locker, one of which had its cap on with the needle still attached and a bit of blood in it. There were also 15-20 Morphine caps in her locker.
Probation 10/06/2012 to 10/06/2017

Martinez, Maggie Mae
Sedalia, MO
Licensed Practical Nurse 2005011435
Respondent was required to obtain continuing education hours Respondent was to have completed these courses and have the certificate of completion for all hours submitted to the Board by June 30, 2012. The Board did not receive proof of any completed hours.
Probation 09/26/2012 to 05/14/2014

Wright, Edna K.
Festus, MO
Registered Nurse 137731
A pharmacy review was done for a thirty day period covering June 14, 2011 through July 10, 2011. The review noted sixteen cases of undocumented narcotics. A second pharmacy review was run for April 7, 2011 through June 13, 2011. Thirty-nine undocumented narcotics were removed from the Pyxis. Licensee admitted that her documentation was lacking.
Probation 10/04/2012 to 10/04/2013

Morris, Cheri Lynn
Willard, MO
Registered Nurse 2005006900
On February 12, 2010, Respondent was assigned to provide care to a pediatric patient of about 12 years of age. The patient had an order for Vancomycin to be delivered intravenously. Respondent, though unsure about the appropriate infusion rate, started the infusion at a rate appropriate for an adult, not a child. As a result of the improper infusion rate, the patient suffered an adverse reaction. Additionally, on May 27, 2010, Respondent was working in the emergency department of St. John's Hospital in Lebanon. During her shift, Respondent behaved in an inappropriate and unprofessional manner in the following ways:
a. Cursing in the presence of patients and co-workers;
b. Speaking inappropriately and sexually about patients and their anatomy;
c. Acting seductively in the presence of patients and co-workers; and
d. Touching co-workers inappropriately.
Probation 09/26/2012 to 09/26/2015

Pahoulis, Ellen Marie
Saint Louis, MO
Registered Nurse 2012034481
On August 26, 2011, Licensee entered into a Board Order with the Virginia Board of Nursing. For approximately one year beginning in late 2009, Licensee diverted morphine and Dilaudid (hydromorphone) from hospital supplies for her own personal and unauthorized use, and she self-administered the medications while on duty.
Probation 10/01/2012 to 10/01/2016

Woods, Melissa Kay
Farmington, MO
Registered Nurse 2012034842
On May 27, 1992, Licensee pled guilty to Excessive Blood Alcohol Content (BAC). On April 19, 2001 License pled guilty to possession of

PROBATION Continued....

a controlled substance, cocaine. On November 2, 2000, Licensee pled guilty to two (2) counts of possession of a controlled substance for possessing cocaine and cocaine base and she pled guilty to possession of drug paraphernalia. On December 20, 2004, Licensee pled guilty to unlawful use of drug paraphernalia and driving while intoxicated (DWI). On September 10, 2009, Licensee pled guilty to DWI-Alcohol-Persistent Offender.
Probation 10/03/2012 to 10/03/2015

Kelley, Amy Sharee
Wilsonville, IL
Licensed Practical Nurse 2012039062
January 21, 2011, Licensee was arrested for Driving While Intoxicated. Licensee received a fine, twenty-two hours of classes, a one hour presentation put on by MADD, and one hundred hours of community services. On April 17, 2011 Licensee received a ticket for driving on a suspended license. Licensee was arrested on August 1, 2010 for assault. Licensee received a suspended imposition of sentence with two years probation and ten hours community service. On January 28, 2007, Licensee was arrested for domestic battery. Licensee received twelve months probation and was required to take a domestic violence class.
Probation 11/08/2012 to 11/08/2014

Blake, John Christopher
Trenton, MO
Licensed Practical Nurse 2006024009
The protocol requires insulin to be held and a physician to be notified if a patient's blood glucose level is below 60. On June 14, 2010, Respondent gave a report to the morning nurse that Patient, F.C., had a glucose reading of 100. On June 14, 2010, patient, F.C., was clammy and had symptoms of being hypoglycemic. On June 14, 2010, patient, F.C's, blood sugar reading was taken shortly after morning report with a result of 28 and then rechecked with a result of 30. Due to patient, F.C.'s, blood sugar readings of 28 and 30, on June 14, 2010, patient, F.C., had to have three glucagon injections to get her blood sugar back up to normal. Respondent's conduct in misreading and/or failing to accurately take patient, F.C.'s blood sugar, resulted in delayed care pursuant to the diabetic protocol and could have been life threatening.
Probation 09/19/2012 to 09/19/2013

DeVore, Katya
Sorento, IL
Registered Nurse 2006019130
Licensee diverted controlled substances while employed at a facility in the State of Illinois. Licensee has been placed in an alternative disposition program with the Circuit Court of the Third Judicial Circuit in Bond County, Illinois for unlawful acquisition of controlled substances. Licensee entered into a Consent Order dated February 9, 2011 with the State of Illinois Department of Financial and Professional Regulation. Licensee admits the allegations that she unlawfully acquired controlled substances. Licensee admitted that she diverted tramadol and Demerol for her personal use from two different employers in the State of Illinois.
Probation 10/04/2012 to 10/04/2016

McMillen, Stephanie L.
Columbia, MO
Licensed Practical Nurse 057144
On April 12, 2011, a prescription was called in to a pharmacy from Dr. B's office. The call on April 12, 2011 was received by a pharmacy technician who was a patient of Dr. B's and recognized Licensee's name when she was calling in the prescription. A woman wearing sunglasses picked up the prescription on the same day, but the pharmacy technician thought she recognized the woman as Licensee. Dr. B had not authorized the prescription. Licensee had also called in four separate prior controlled substance prescriptions
February 21, 2011-Norco 10/325
January 14, 2011-Lortab 10/650
December 15, 2010-Lortab 10/650
November 19, 2010-Lortab 10/650
Dr. B had not authorized any of these prescriptions. On April 13, 2011, Licensee admitted that she had called in prescriptions for herself using Dr. B's DEA number and signature and without his authorization.
Probation 10/30/2012 to 10/30/2017

Mackey, Jennifer Marie
Kansas City, MO
Licensed Practical Nurse 2007029429
On July 29, 2011, Licensee contacted the Board's office and it was explained to her how to renew her license. On September 15, 2011, a petition for a licensed practical nurse was mailed to Licensee. On December 29, 2011, Board staff again explained to Licensee how to renew her license. Licensee knew that her licensed practical nursing license was lapsed since at least July 29, 2011, when she was performing the services and duties of a licensed practical nurse from May 31, 2010 through December 15, 2011.
Probation 10/01/2012 to 10/01/2013

Evans, Marci Elizabeth
Carl Junction, MO
Registered Nurse 2012039675
Licensee entered an inpatient substance abuse program on March 12, 2012, and successfully completed the program on May 18, 2012. Licensee states she last abused alcohol on March 11, 2012. She reported that she was a binge drinker and her last binge was from March 8, 2012 through March 11, 2012.
Probation 11/26/2012 to 11/26/2017

Evans, Candice Richelle
Cape Girardeau, MO
Licensed Practical Nurse 2012039352
On April 20, 1999 Licensee pled guilty to the Class A Misdemeanor of passing bad checks. On March 14, 2000, Licensee pled guilty to the Class A Misdemeanor of passing bad checks. On June 20, 2000, Licensee pled guilty to the Class A Misdemeanor of passing bad checks. May 13, 2010, Licensee pled guilty to the Class C Felony of possession of marijuana.
Probation 11/19/2012 to 11/19/2015

Schoonover, Kimberly Ann
Tarkio, MO
Licensed Practical Nurse 2008032151
Licensee told C.K., Business Office Manger, that she diverted insulin from the facility and injected herself attempting to kill herself. Licensee

Probation continued on page 18

The Board of Nursing is requesting contact from the following individuals:

Sonjia Cahill–RN138397
Susan Contreras-Scheufens–RN2010030582
Denise Filla–PN2004001920
Nahdeen Joseph–PN2005035418
Robyne L. Maxville–PN036049
Holly McFadden–RN2007014364
Carolyn Sargent–PN054569
Martha Witcher–RN081502

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@pr.mo.gov

Schedule of Board Meeting Dates Through 2014

March 5-8, 2013
June 4-7, 2013
September 3-6, 2013
December 3-6, 2013
March 4-7, 2014
June 3-6, 2014
September 2-5, 2014
December 2-5, 2014

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at http://pr.mo.gov

Board of Nursing E-Alerts– Disciplinary Actions

You can now subscribe to Board of Nursing E-Alerts.

Every Monday we will send you an email with an Excel file that contains the names, license numbers and professions of any nurse whose license has been disciplined by the Board of Nursing the preceding week.

Discipline may include license revocations, suspensions, probations or other actions.

You can then go to www.nursys.com to see the details of the discipline including the Board's order.

To subscribe to the e-alerts, send your name and email address to Lori Scheidt at lori.scheidt@pr.mo.gov

Probation continued from page 17

admitted to drinking a lot of beer and liquor together every night to get drunk and was afraid that she was becoming dependant on alcohol prior to her suicide attempt.
Probation 10/30/2012 to 10/30/2014

Powell, Jessica Marie
Kirksville, MO
Registered Nurse 2009003985
Licensee was employed from July 5, 2011 until she was terminated on August 26, 2011. On Sunday, August 21, 2011 Licensee was working in the Emergency Department (ED). Patient E.Y. was still being triaged by another registered professional nurse and had not been admitted into the hospital when Licensee withdrew a vial of Hydromorphone purportedly for E.Y. E.Y. did not have a physician's order for Hydromorphone. When confronted about the Hydromorphone, Licensee retrieved the vial and brought it to the RN Director and house supervisor. The vial top had been punctured. The vial was sent to a lab for testing and the test result revealed the Hydrocodone in the vial had been diluted. As a result, an investigation was done by the RN Director and house supervisor by reviewing the Pyxis and records regarding Licensee. The investigation revealed that Licensee had Hydromorphone discrepancies. Licensee denied diverting the Hydromorphone on August 21, 2011, but did admit that she had been diverting Dilaudid from her employer for personal consumption. Dilaudid is the brand name of Hydromorphone.
Probation 11/13/2012 to 11/13/2017

Turner, Deborah Lynn
Kennett, MO
Licensed Practical Nurse 2000168027
On December 27, 1990. Licensee pled guilty to driving while intoxicated. On March 11, 2004, Licensee pled guilty to driving while intoxicated. On December 2, 2008, Licensee pled guilty to driving while intoxicated, prior offender.
Probation 10/29/2012 to 10/29/2015

Mayoral, Karen P.
Columbia, MO
Registered Nurse 2005037769
On April 3, 2010, Respondent was requested to submit to a drug screen after she was observed exhibiting strange behavior during her shift. Respondent initially agreed to take the drug test and signed a form agreeing to the test. Respondent then told her supervisor she did not want to take the test due to using cocaine within the past couple of days prior to April 3, 2010.
Probation 09/26/2012 to 09/26/2017

Lewis, Jana E.
Springfield, MO
Registered Nurse 147777
On June 12, 2010, a prescribed pill vial in a pharmacy bag for an employee of the facility was delivered to the Emergency Room triage desk by a pharmacy employee. The prescription vial contained thirty

PROBATION Continued....

Adderall 20 mg tablets. Security camera footage revealed that the Licensee removed the prescription from the desk drawer. The employee notified security that Licensee gave him the missing prescription vial. No pills were missing from the prescription. When interviewed by hospital security, Licensee admitted that she removed the Adderall from the triage desk. She further admitted that she had no valid reason to remove the Adderall from the desk or from the unit.
Probation 09/19/2012 to 09/19/2013

Clay, Jaunice S.
Saint Louis, MO
Licensed Practical Nurse 053062
On September 28, 2010, Respondent was asked to take a random drug screen. Respondent's urine sample tested positive for cocaine.
Probation 09/19/2012 to 09/19/2017

Hurshman, Carla M.
Blue Springs, MO
Registered Nurse 2012033102
On September 7, 2004, Licensee voluntarily surrendered her license in Missouri to practice as a registered nurse. The facts surrounding this voluntary surrender are as follows:
On March 20, 2003, Licensee diverted one tablet of Lortab. On or about April 2, 2003, Licensee diverted one tablet of Lortab. On or about April 2, 2003, Licensee diverted one tablet of Percot. On or about July 15, 2009, Licensee entered into an agreement with the Kansas State Board of Nursing, stipulating that she diverted Demerol on June 10, 2004. The Kansas State Board of Nursing issued disciplinary action, and Licensee was granted a license with limitations on her practice and participation in the Kansas Nurses Assistance Program.
Probation 09/17/2012 to 09/17/2014

Kohnz, Garrett Alan
Columbia, IL
Registered Nurse 2012031276
On March 21, 2007, Licensee pled guilty to the offenses of involuntary manslaughter while driving under the influence of alcohol or drugs and failure to stop and render aid to an injured party in the State of Kansas. The Court sentenced Licensee to serve a sentence of sixty (60) months in prison.
Probation 09/04/2012 to 09/04/2015

Norfleet, William C.
Saint Louis, MO
Licensed Practical Nurse 033536
On June 18, 2012, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol. On August 6, 2012, Respondent again was chosen to report to a collection site to provide a sample. Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol.
Probation 09/26/2012 to 07/06/2015

Chambers, Marie A.
Wheatland, MO
Licensed Practical Nurse 054805
On October 27, 2011, Licensee received an order on H.D. for Lisinopril 5 mg BID, which she noted and transcribed to the Medication Administration Record (MAR). The physician then called back the same day, October 27, 2011, and changed the Lisinopril order back to the original order of 5 mg daily, monitor the resident, and to notify physician of findings after a week of vital signs. Licensee did not rewrite the order, she put a line through the first order she received, "errored" it out, and wrote the new order. Licensee failed to change the MAR causing the resident to receive Lisinopril BID (twice daily) instead of once daily for four (4) days in contravention of the physician's order. On June 23, 2011, at 2200, Licensee counted narcotics with the off-going nurse and signed that the count was accurate. Licensee did not visually count a resident's Hydrocodone/APAP 5/500mg. On June 24, 2011, at the 0600 shift count, it was discovered that a resident's Hydrocodone/APAP 5/500mg was short by seven (7) pills. Licensee had not signed out two (2) Hydrocodone/APAP 5/500mg that she had administered; thus, making the count short by five (5) pills.
Probation 10/11/2012 to 10/11/2013

PROBATION Continued....

Fister, Samantha Rae
Barnhart, MO
Licensed Practical Nurse 2003022279
Licensee admitted that she had been diverting the Tramadol from her employer. Licensee stated that her Tramadol addiction to Tramadol started in December 2010 after she had surgery.
Probation 11/13/2012 to 11/13/2017

Gann, Tonya Marie
Cabool, MO
Licensed Practical Nurse 2012039064
On May 4, 2009, Licensee pled guilty to possession of a controlled substance. She received a suspended imposition of sentence and was placed on five (5) years of supervised probation. She was released early from probation on December 19, 2011. On June 5, 2009, Licensee plead guilty to leaving the scene of a motor vehicle accident. She received a suspended imposition of sentence and was placed on two years probation. Licensee self-reported that she previously abused methamphetamine.
Probation 11/08/2012 to 11/08/2015

SUSPENSION/PROBATION

Smith, Brian William
Kearney, MO
Registered Nurse 2003017238
Suspended 10/17/2012 to 11/20/2012
Probated 11/20/2012 to 11/20/2017
On July 13, 2011, Licensee was asked to submit to a for cause drug screen. The alcohol screening results were .121 and .122. On July 22, 2011, Licensee signed a return to work agreement with the facility. Licensee returned to work at the facility on August 22, 2011 after successfully completing a treatment program. On September 23, 2011, Licensee was asked to submit to a for cause drug screen due to reports of withdrawn mood, frequent trips to the rest room, glassy and blood shoot eyes, and an odor of alcohol on his breath. The alcohol screening results were .157, .144, and .150.
Suspension 10/17/2012 to 11/20/2012; Probation 11/20/2012 to 11/20/2017

Voss, Elizabeth Maria
Iberia, MO
Registered Nurse 2010010363
Suspended 10/18/2012 to 11/17/2012
Probated 11/18/2012 to 11/18/2017
Licensee signed an Employment Agreement on May 16, 2011, as the result of Licensee having a positive blood alcohol test at work. Licensee was tested on May 10, 2011 and the test result was positive for alcohol with a blood-alcohol level of .10%. On August 9, 2011, the House Supervisor notified the Vice President of Human Resources that he had received a report that Licensee was behaving strangely and that there was suspicion that she was impaired and the allegation that there was beer in Licensee's backpack. Licensee stated that she had been drinking yesterday and allowed staff to look in her backpack which contained two large full bottles that appeared to be water. Staff then asked Licensee if she would object to a having a blood alcohol screen done in the lab. Licensee stated she had no objection and the sample was drawn. The test results revealed that Licensee's blood alcohol level was .144%.
Suspension 10/18/2012 to 11/17/2012; Probation 11/18/2012 to 11/18/2017

Cox, Sharon Denise
Florissant, MO
Licensed Practical Nurse 2008026379
Suspended October 30, 2012 to April 30, 2014
Probated May 1, 2014 to May 1, 2016
On June 3, 2011, the Department of Health and Senior Services (DHSS) completed an investigation of a complaint alleging falsification of documentation verifying service delivery to P.G., an in-home services client. P.G.'s daughter reported that a nurse was not visiting her mother. Licensee admitted to the DHSS investigator and the Board

Suspension/Probation continued on page 19

Suspension/Probation continued from page 18

investigator that she forged P.G.'s name on her nurse visit reports. The DHSS nvestigation revealed that there were 24 nursing visits for which Licensee falsified signatures for clients she did not actually visit.
Suspension 10/30/2012 to 04/30/2014; Probation 5/31/2012 to 5/1/2016

Revoked

Ryan, Tammy M.
Doniphan, MO
Registered Nurse 2000165262
Respondent failed to call in to NTS on January 12, 2012; March 8, 2012; March 9, 2012; March 12, 2012; March 13, 2012; March 14, 2012; April 26, 2012; May 17, 2012; and from May 30, 2012 through July 9, 2012. Further, on February 21, 2012, April 19, 2012, and May 29, 2012, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on November 9, 2011, provided the required sample which had a creatinine reading of 9.1. A creatinine reading below 20.0 is suspicious for a diluted sample. Respondent was required to submit updated treatment information from a chemical dependency professional by due dates provided to her. The Board did not receive updated treatment chemical dependency information submitted on Respondent's behalf by the November 30, 2011 and February 29, 2012, documentation due dates. Respondent was required to attend a support group and submit the support group attendance reports to the Board by due dates provided to her. The Board did not receive proof of support group attendance by the November 30, 2011 and February 29, 2012, documentation due dates.
Revoked 09/13/2012

Gotsch, Mary Lynn
Carrollton, MO
Licensed Practical Nurse 042132
Between December 6, 2011 and July 26, 2012, Respondent failed to call in to NTS on two (2) days. Respondent was required to abstain completely from the use or possession of any controlled substance or other drug for which a prescription is required unless use of the drug had been prescribed by a person licensed to prescribe such drug and with whom Respondent had a bona fide relationship as a patient. On June 5, 2012, Respondent submitted a urine sample for random drug screening to NTS. That sample tested positive for the presence of Methamphetamine. Respondent was required to completely abstain from the use or consumption of alcohol in any form, regardless of whether treatment was recommended. On June 18, 2012, Respondent reported to a collection site to provide a sample to NTS and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol.
Revoked 09/13/2012

Pemble, Amy Marie
Ballwin, MO
Registered Nurse 2006018964
Licensee admitted to diversion of controlled substances from Des Peres Hospital throughout the summer of 2010. Licensee admitted to diverting morphine, lithium, clonazepam, and trazadone, all controlled substances, from various nursing jobs. On March 2, 2012, Licensee pled guilty to three (3) counts of theft/stealing any controlled substance.
Revoked 10/04/2012

Elliott, Linda S.
Kansas City, MO
Licensed Practical Nurse 046278
On March 25, 2010, resident, J.E., complained of urine leakage and requested Respondent's assistance. Respondent removed the old catheter and did not wear sterile gloves. Respondent proceeded to cut the end of the old catheter with a pair of scissors while the rest of the catheter was still inside of the resident. Respondent did not use a syringe to aspirate all the fluid used to inflate the balloon mechanism of the catheter. J.E., complained that Respondent was pulling on the catheter too hard and that it was causing her pain. When Respondent thereupon began to insert a new catheter into resident J.E., Respondent failed to clean the resident's genitalia and perineum before attempting to insert the catheter. Respondent failed to use any lubricant in inserting the catheter. Respondent failed to clean the connector tip of the catheter. Respondent improperly opened the saline packages with her teeth and did not use gloves. On March 25, 2010, Respondent removed male resident, L.N.'s catheter and inserted a new one. Respondent tried to instill fluid into the balloon of resident, L.N.'s catheter instead of deflating the balloon first. On March 25, 2010, resident, P.K., fell down and Respondent failed to assess him for injuries or report the incident after the incident was reported to her. On March 25, 2010, resident, J.R., asked Respondent for his evening accucheck and Lantus insulin. After resident J.R. asked on March 25, 2010, resident J.R. fell asleep around 8:30 p.m. or 9:00 p.m. without receiving his accucheck or Lantus insulin. On March 25, 2010, Respondent failed to give resident J.R., his evening accucheck and Lantus insulin. Resident J.R.'s blood sugar reading the next morning was elevated.
Revoked 10/01/2012

Elliston, Jill L.
Nixa, MO
Registered Nurse 101759
On February 24, 2009, Respondent's employer was contacted by a patient's daughter who complained that her father (the patient) had not been seen by a nurse in over a month. The patient was on Coumadin which required frequent monitoring of his blood. Upon checking the patient's chart, Respondent's supervisor found records which indicated Respondent had completed an OASIS assessment for the patient on February 4. 2009. The records in the chart purported to bear the patient's signature; however, upon presenting the records to the patient, both the patient and his daughter denied the signature was his and also denied that Respondent had been to their home on February 4, 2009. Respondent was only assigned four or five patients at that time. An audit of all of Respondent's patient charts indicated another discrepancy of signatures for two alleged dates of service for another patient. Respondent documented visits on January 23, 2009 and February 3, 2009 to a patient. The patient signatures on the records for these two visits did not match the previous signatures obtained from the patient on other visits. Respondent's supervisor contacted the patient, who when presented with the records purporting to have the patient's own signature, also denied that was her signature and denied that Respondent had been to her home on January 23, 2009 or February 3, 2009.
Revoked 09/26/2012

Gaddis, Merry Wayne
Prairie Village, KS
Registered Nurse 2011030943
On October 24, 2011, the Board issued a Modification Order, which required Respondent to submit compliance reports from the Kansas Nurses Assistance Program (KNAP), and stated that failure to comply with the terms of KNAP would be considered a violation of her probation. On July 30, 2012, the Board, received a letter from Regena M. Walter, KNAP Program Manager. The letter indicated that Respondent chose to leave the nursing profession and that Respondent's KNAP file was then closed as unsuccessful. On July 30, 2012, Respondent was instructed to contract with NTS and participate in random drug and alcohol screenings as part of her Missouri probation as Respondent was no longer in KNAP. Respondent did not contract with NTS.
Revoked 09/18/2012

Young, Lynnette Renee
Viburnum, MO
Registered Nurse 2003016418
The Administrative Hearing Commission found cause for the Board to discipline Respondent's license for diverting controlled substances for her own use, maintaining inaccurate patient records and failing to properly dispense, administer and waste medications.
Revoked 09/18/2012

Shelton, Brandi Rae
De Kalb, MO
Licensed Practical Nurse 2008025205
An investigation into Respondent's time sheets and flow sheets from January 5, 2012, and January 6, 2012, for patient 00331 revealed that Respondent had falsified her time sheets, taken confidential information from patient 00331's home and forged the signature of patient 00331's mother on patient 00331's flow sheet, reflecting that Respondent worked those hours reflected on the flow sheet.
Revoked 09/12/2012

Rittman, Sarah Christine
Lees Summit, MO
Registered Nurse 2008021528
From September 23, 2011 through August 17, 2012, Respondent failed to call in to NTS on five (5) days. On October 20, 2011, Respondent submitted the required sample which showed a low creatinine reading of 15.7. On January 5, 2012, Respondent submitted a sample which showed a creatinine reading of 18.2. Creatinine readings below 20.0 are suspicious for diluted samples. On May 22, 2012, Respondent reported to a collection site to provide a sample, and the sample tested positive for marijuana. On June 26, 2012, Respondent reported to a collection

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site to provide a sample and the sample tested positive for Marijuana. Respondent failed to submit chemical dependency evaluation updates by the April 19, 2012, and the July 19, 2012, documentation due dates. Respondent failed to submit an employer evaluation or statement of unemployment by the July 19, 2012, documentation due date.
Revoked 09/12/2012

Valenzuela, Sonja Jeanette
Holts Summit, MO
Licensed Practical Nurse 2009026465
Respondent failed to call the third-party administrator since June 22, 2012 through August 10, 2012. In addition, on June 26, 2012 and July 16, 2012, Respondent failed to call NTS; however, both were days that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on June 26, 2012 and July 16, 2012. Respondent was additionally required to undergo and have submitted to the Board a thorough chemical dependency evaluation by June 27, 2012. The Board did not receive a chemical dependency evaluation.
Revoked 09/13/2012

Harper, Patricia Kathleen
Foristell, MO
Licensed Practical Nurse 2007033496
On May 29-30, 2012, Respondent was scheduled to work from 6:00 p.m. to 6:00 a.m. and was responsible for direct patient care at the Center.
Respondent was responsible for caring for Patient, J.G., who has a history of pneumonia and congestive heart failure, making him a high risk patient. Patient, J.G., became ill on Respondent's shift, and Respondent was assigned to care for him. In relation to her care of J.G. during her shift, Respondent failed to document a lung assessment, failed to document lung sounds, failed to document whether the patient had any edema or swelling, failed to document complete vital signs and failed to document the patient's mental status at 2050 despite the fact that the patient was experiencing shortness of breath, had blue lips, and an oxygen saturation of 63% and a pulse of 145. The patient was also non-compliant with wearing his oxygen. Respondent failed to document the patient's respirations despite noting he was experiencing shortness of breath. Respondent did call the patient's doctor at 2050 and again at 2105. Respondent checked on Patient, J.G., at 2130 after his doctor returned Respondent's phone call. The patient's oxygen saturation level was documented at 86%. Respondent charted that she was monitoring J.G. closely and frequently at 2130; however, Respondent failed to chart any further assessments or vital signs on J.G. after 2130 through the rest of her shift. Respondent failed to document a lung assessment, failed to document lung sounds, failed to document whether the patient had any edema or swelling, failed to document complete vital signs and failed to document the patient's mental status at 2130. Respondent failed to document anything about the patient's condition after 2130 through the end of her shift at 6:00 a.m. Respondent stated that she checked on the patient J.G. at 5:30 a.m. and the patient was not wearing oxygen. She placed the oxygen back on J.G. When asked by the Board's investigator why she failed to document assessments on J.G. she reported she had actually done only visual assessments at 12:00 a.m.; 3:00 a.m. 4:00 a.m.; and, 5:30 a.m., and that it slipped her mind to actually document them. She did not do vital signs, check his lungs, oxygen SAT or check his color on any of these occasions. Respondent stated to the Board's investigator that she did have notes she made during this shift in question that were not documented in the patient's chart. When the day nurse at the Center assumed care for Patient, J.G, at 8:10 a.m., on the next shift, he was not wearing his oxygen and was noted to have rapid and open-mouthed breathing. His oxygen saturation level was 80% and he was noted to have edema on his feet, ankles and hands. The patient also had coarse lungs throughout a nebulizer treatment given to him that morning.
Revoked 10/15/2012

Jacobs, Tannia Devette
Saint Louis, MO
Registered Nurse 2007010041
Respondent has failed to call in to NTS on eleven (11) occasions. Further, on May 17, 2012, May 31, 2012 and June 5, 2012, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, January 23, 2012 and June 8, 2012, Respondent was selected to provide a urine sample for screening and the result of the screening showed low creatinine readings. On January 23, 2012, the low creatinine reading was 11.5. Respondent's creatinine reading was 10.7 for the June 8, 2012, sample. A creatinine reading below 20.0 is suspicious for a diluted sample and a diluted sample is considered a failed drug and alcohol test. Proof of counseling attendance was due to the Board by June 18, 2012. The Board did not receive proof of completion of any counseling attendance on behalf of Respondent, until June 20, 2012. Respondent was required to obtain continuing education hours covering and have the certificate of completion for all hours submitted to the Board by June 20, 2012. The Board did not receive proof of any completed hours.
Revoked 09/20/2012

Cleek, Marion Ann
Eldon, MO
Registered Nurse 150985
Respondent was responsible for completing admission assessments on new residents. On December 3, 2009, the Respondent failed to complete this responsibility in accordance with facility policy and was disciplined by the facility for improper conduct. Respondent was charged with administering medication to residents in accordance with physician orders and facility policy. During April, 2010, a resident had an order for Clonazepam 0.5 mg to be administered at 8:00 a.m. and 4:00 p.m. Respondent was questioned about the administration of medications when the 4:00 p.m. dose was not given until 9:00 p.m. by Respondent. Respondent was counseled by her employer for this violation of facility policy. Respondent also changed administration times on two dates in April, 2010 from "9:00 p.m." to "4:00 p.m." on the controlled drug administration record of the facility. This conduct occurred after an investigation had begun of Respondent's charting on various patients' records. On May 18, 2010, facility administration counted the number of medications on the medication cards prior to the Respondent's 6:00 p.m. medication "pass" for residents under her responsibility. Facility administration then counted the medications on the medication cards following Respondent's 6:00 p.m. medication pass. Facility administration discovered that medications that were scheduled to be administered at 8:00 p.m. had already been removed and administered by Respondent, before 8:00 p.m. It was discovered by facility administration that Respondent would routinely administer

REVOKED Continued....

the residents' 4:00 p.m., 6:00 p.m., and 8:00 p.m. medications all in one medication pass. Respondent admitted to facility administration to giving the medications all during one medication pass for several residents.
Revoked 10/15/2012

Hall, Allison B.
Florissant, MO
Registered Nurse 099498
Respondent was required to obtain continuing education hours covering and have the certificate of completion for all hours submitted to the Board by August 6, 2012. The Board did not receive proof of any completed hours.
Revoked 09/26/2012

Barnes, Patricia A.
Saint Joseph, MO
Licensed Practical Nurse 040044
On August 11, 2012, the Board received a support group meeting report with a facsimile notation of that same date on the top of the report alleging that Respondent attended support group meetings on August 21, August 22, August 29, August 30, September 1, September 3, September 8, and September 10, 2012. Respondent admitted that she had ceased attending support group meetings and that she falsified the support group meeting report that she submitted to the Board.
Revoked 09/13/2012

Hendricks, Brett L.
Saint Louis, MO
Licensed Practical Nurse 050788
Respondent was the charge nurse on the first floor. On June 5, 2010, several employees of the facility found Respondent to be impaired. Respondent was having difficulty with his balance, slurring his speech, fumbling through paperwork, staggering to his vehicle, falling asleep, spilling water on patient records, and entering the wrong resident's room. Respondent locked himself in the medication room at the facility. Respondent was found by a certified nurse aide in the medication room. Respondent's pupils were observed to be "as big as dimes" and he asked the certified nurse aide if he wanted to count meds with him, but nurse aides are not allowed to count medications. Respondent was escorted out of the facility. Respondent then entered his vehicle, drove two blocks, and wrecked his vehicle into the median. After Respondent left, facility staff conducted a count of the medications in the medication room. The staff found 8ML of morphine were missing and a bottle of liquid Ativan left on the counter along with water on the counter and floor. The Ativan bottle appeared too thin and too full; staff determined the Ativan was watered down. Respondent failed to treat his patients in the following ways: Barrier cream was not applied to F.P.; Antiseptic was not applied to M.V.; Topical anti-inflammatory cream was not applied to J.P.'s face; Topical cream was not applied to B.K.'s left hand; Barrier cream and anti-itch cream were not applied to M.Y.; Dressing to both knees of M.T. was not applied.
Revoked 09/26/2012

Jay, Samantha M.
Montgomery City, MO
Licensed Practical Nurse 2004011890
Respondent failed to call in to NTS on two (2) days. Further, on May 22, 2012, Respondent submitted a sample which resulted in an invalid sample. The creatinine level was 1.9. Creatinine levels below 20.0 are suspicious for a diluted sample. Respondent was required to obtain continuing education hours and have the certificate of completion for all hours submitted to the Board by June 28, 2012. The Board has not received proof of any completed hours. Respondent was required to comply with the Nursing Practice Act. Respondent self-terminated from a facility and it was discovered that she had signed her 2:00 p.m. and 4:00 p.m. medications out prior to leaving her shift at 11:54 a.m. and did not administer the medications.
On December 7, 2011, Licensee pled guilty to two counts of felony Possession of a Controlled Substance, one count of misdemeanor of Possession of a Controlled Substance and Possession of Drug Paraphernalia.
Revoked 09/18/2012

Drowns, Jonathan E.
Saginaw, MO
Registered Nurse 149366
Respondent failed to report to a collection site to provide the requested sample on July 26, 2012. Respondent was also required to submit a thorough chemical dependency evaluation to the Board by May 18, 2012. The Board never received a chemical dependency evaluation submitted on behalf of Respondent.
Revoked 09/18/2012

Madden, Janice D.
Ballwin, MO
Registered Nurse 116733
Respondent failed to submit an employer evaluation or statement of unemployment by the January 27, 2012 and the July 27, 2012, documentation due dates.
Revoked 09/13/2012

Archer, Tami Renee
Liberty, MO
Licensed Practical Nurse 2004029008
Respondent failed to call in to NTS on four (4) different days. Further, on April 9, 2012, May 10, 2012, May 15, 2012, June 5, 2012, July 3, 2012, and July 27, 2012, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample on each of those dates. In addition, on June 19, 2012, Respondent failed to call NTS; however, it was a day that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on June 19, 2012. In addition, on February 7, 2012, when Respondent did report to the lab and submitted the required sample after being prompted to on the daily phone call to NTS, this sample showed a low creatinine reading of 16.4. A creatinine reading below 20.0 is suspicious for a diluted sample. A diluted sample is considered a failed test.
Revoked 09/26/2012

Emery, Christina Eileen
Ravenwood, MO
Registered Nurse 2009019684
On three (3) occasions, Respondent was advised that she had been

REVOKED Continued....

selected to provide a urine sample for screening and Respondent failed to report to a collection site to provide the requested sample.
Revoked 09/26/2012

Burchfield, Stephanie Marie
Staunton, IL
Registered Nurse 2003021308
The Administrative Hearing Commission found cause to discipline Stephanie Burchfield for misappropriating a controlled substance from the medical facility where she worked in Florida and because the Florida State Board of Nursing ("the Florida Board") reprimanded her registered professional nurse license for this conduct.
Revoked 09/13/2012

Scheuler, Teri L.
Mayview, MO
Registered Nurse 100690
On June 29, 2007, staff at a facility was contacted by the mother of one of their patients. Patient, R.B. is a 45-year old male who is considered permanently disabled. He has no left sided brain functioning. Patient, R.B. also has a history of substance abuse and self-inflicted injuries. Since patient, R.B.'s discharge on May 15, 2007, Respondent began calling him and text-messaging him repeatedly. Patient, R.B. left his wife and moved in with Respondent within two weeks of her contact with him. Patient, R.B. stated that Respondent was trying to get him to buy a truck for her and Respondent also asked him to purchase a gun. On July 3, 2007, Respondent was observed by staff leaving the hospital with patient, R.B. and getting into a car together. A search of Respondent's locker revealed a 14-inch Bowie knife in her possession. This possession of such a knife inside the hospital was a violation of policy, due to the possibility of damage a knife could cause in any psychiatric or other setting. Patient, R.B. also stated he had co-signed for Respondent so she could get a car loan. Patient, R.B. was re-admitted on August 16, 2007, with complaints of anxiety and anger. Patient, R.B. stated that he was being harassed by a woman he had an affair with, and he was feeling hopeless, helpless, and having suicidal thoughts
Revoked 10/01/2012

Adkison, Dianne
Louisiana, MO
Registered Nurse 067108
Respondent failed to call in to NTS two (2) different times. On July 17, 2012, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol. On July 23, 2012, Respondent admitted to a Medical Review Officer with NTS that she had consumed alcohol.
Revoked 09/26/2012

Winscott, Reta Sue
Columbia, MO
Licensed Practical Nurse 2006011468
On April 1, 2009, Respondent had a drug screen that tested positive for Butalbital. Licensee did not have a valid prescription for Butalbital. On September 5, 2008, Respondent indicated on patient M.R.'s chart that Roxicet was verbally ordered for patient M.R. by Dr. Morgan. When questioned about the order, Dr. Morgan denied giving the order. First, patient M.R. was not a patient of Dr. Morgan's and secondly, the prescription order was incomplete and written for the wrong dosage.
Revoked 10/01/2012

Berry, Carrie L.
Independence, MO
Licensed Practical Nurse 051027
The Administrative Hearing Commission found that Respondent's license was subject to discipline for illegally possessing controlled substances.
Revoked 09/18/2012

VOLUNTARY SURRENDER

Blair, Angela L.
Carrollton, MO
Licensed Practical Nurse 042124
On April 2, 2011, one of the patients in Licensee's care fell from her bed and was found on the floor by a certified nursing assistant ("CNA") at 4:30 A.M. The CNA reported finding the patient on the floor to Licensee, who was the CNA's supervisor. Licensee assisted the CNA with returning the patient to her bed. Licensee told the CNA to not say anything to anyone about the patient falling out of bed. Licensee failed to document the fall or the patient's condition after the fall. Licensee did not report to the on coming nurse that the patient had fallen. The on coming nurse discovered the patient in pain and learned about the fall when she examined the patient and questioned the patient on the source of the pain.
Voluntary Surrender 10/26/2012

Atkins, Phyllis A.
Harrisburg, MO
Registered Nurse 131762
On December 5, 2011, Licensee pled guilty to the three counts of Fraudulently Attempting to Obtain Controlled Substances.
Voluntary Surrender 11/26/2012

Brown, Karen Renee
Lebanon, MO
Registered Nurse 2000149110
Licensee was employed as a staff nurse in the Intensive Care Unit (ICU) and as a charge nurse in the Med/Surg Unit from August 26, 2002 until December 16, 2011 when she was terminated her for drug diversion. The employer requested that Licensee take a drug test. Licensee tested positive for Demerol and Dilaudid. Licensee did not have a valid prescription for Demerol or Dilaudid.
Voluntary Surrender 11/07/2012

Ridinger, Dennise A.
Springfield, MO
Licensed Practical Nurse 047506
Licensee's Clinical Supervisor, A.R., worked as a private duty nurse

Voluntary Surrender continued on page 21

Voluntary Surrender continued from page 20

in the home of a client in March of 2011. Licensee was assigned to the client's home after A.R.'s duties changed. While working in the client's home, A.R. misplaced her watch and ring. The client found the watch and returned it to A.R., but did not find the ring. On August 17, 2011, Licensee met with A.R. for Licensee's yearly evaluation. When Licensee arrived for the evaluation, she was wearing A.R.'s ring. A.R. asked Licensee where she had gotten the ring. Licensee stated she had gotten it from the client's house. A.R. told Licensee it was her ring and she had lost it at the client's house. Licensee admitted to taking the ring from the client's house and stated, "Oh I was just waiting for the client to say they had lost it." Licensee returned the ring to A.R.
Voluntary Surrender 10/17/2012

Dyet, Anita F.
East Wenatchee, WA
Registered Nurse 089079
Voluntary Surrender 09/12/2012

Myers, Claudia J.
Moberly, MO
Registered Nurse 140421
On or about October 6, 2009, in The Circuit Court of Macon County, MO, Licensee entered a plea of guilty to the Class B misdemeanor of driving while intoxicated in violation. She received 30 day suspended execution of sentence with two years of supervised probation and special conditions. Driving while intoxicated is a crime of moral turpitude.
Voluntary Surrender 09/04/2012

VOLUNTARY SURRENDER Continued....

Holcomb, Chase Logan
Rogersville, MO
Registered Nurse 2009038786
On October 30, 2010, while on duty as a nurse, Licensee exposed his genitalia to a female co-worker. On June 6, 2011, Licensee pled guilty to the Class B Misdemeanor of "Sexual Misconduct in the Second Degree" in the Associate Circuit Court of Greene County, Missouri.
Voluntary Surrender 11/03/2012

Gunn, Michelle Renee
Lees Summit, MO
Registered Nurse 2005025829
Licensee voluntarily surrendered her Missouri nursing license on September 4, 2012.
Voluntary Surrender 09/04/2012

If Your Patient Was Abusing Prescription or Illicit Drugs, Would You Know?

The National Institute on Drug Abuse, National Institutes of Health

In 2011, 3.1 million persons aged 12 or older reported using an illicit drug for the first time within the past 12 months. This averages to approximately 8,500 initiates per day[1]. Additionally, 6.1 million persons aged 12 or older reported the nonmedical use of prescription psychotherapeutic drugs in the past month[1].

The National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, has developed NIDAMED, a portfolio of resources designed to help nurses and other clinicians better address drug abuse in their patients. Visit the NIDAMED Web site now to view the portfolio of science-based, free resources: http://www.drugabuse.gov/nidamed-medical-health-professionals.

Available materials include:

- The NIDA Drug Use Screening Tool—a one question quick screen and a full interactive screen
- Information guides on brief intervention and referral to treatment
- Two new Medscape CEs about substance abuse topics
- Patient materials
- Curriculum resources for students about drug abuse and addiction

If you have questions about any of the NIDAMED resources, contact nidacoeteam@jbsinternational.com.

[1]Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Summary of national findings, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration.

NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ PHONE CHANGE

_____ ☐ RN ☐ LPN ☐ APRN _____
Missouri License Number Social Security Number

→_____ _____
Signature *(This form must be signed)* Date

NAME AS CURRENTLY IN OUR SYSTEM

_____ _____
First Name (Printed) Last Name (Printed)

NEW NAME

_____
Last Name First Name Middle Name

PRIMARY STATE OF RESIDENCE ADDRESS: (where you vote, pay federal taxes, obtain a driver's license)

Physical address required, **PO boxes are not acceptable**

CITY STATE ZIP

(_____)_____ _____
Daytime Telephone Number E-mail Address

MAILING ADDRESS (ONLY REQUIRED IF YOUR MAILING ADDRESS IS DIFFERENT THAN PRIMARY RESIDENCE)

STREET OR PO BOX

CITY STATE ZIP

☐ **I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.**

Return completed form to: Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or

Fax to 573-751-6745

If you wish to obtain a duplicate license you must return this form along with your current wallet-size license and a $15.00 check or money order payable to the Missouri Board of Nursing.